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EXPERIENTIAL PSYCHOTHERAPY: ITS THEORY, RESEARCH, CLINICAL PRACTICE, AND HISTORICAL DEVELOPMENT

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University of New Hampshire

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EXPERIENTIAL PSYCHOTHERAPY:
ITS THEORY, RESEARCH, CLINICAL PRACTICE,
AND HISTORICAL DEVELOPMENT.

BY

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M.A., University of New Hampshire, 1983
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DISSERTATION

Submitted to the University of New Hampshire
in Partial Fulfillment of
the Requirements for the Degree of

Doctor of Philosophy
in
Psychology

May, 1984

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ABSTRACT

EXPERIENTIAL PSYCHOTHERAPY: ITS THEORY, RESEARCH, CLINICAL PRACTICE, AND HISTORICAL DEVELOPMENT.

by

JERRY L. JENNINGS

University of New Hampshire, May 1984

Experiential psychotherapy evolved historically from Carl Rogers' client-centered approach. Traditionally, client-centered researchers have been determined to find better ways to experimentally study and understand complex subjective experience and personality change. By the mid-1950's, Rogers increasingly appreciated the essential process nature of the therapeutic experience. This marked a vital theoretical shift from an established "static content" view of personality to the "new process conception."

Meanwhile, coming from an educational background in existential philosophy and phenomenology, Eugene Gendlin contributed the unique process theory called "experiencing." Gendlin advanced the "new process conception" by clarifying the crucial distinction between direct experiencing as it is immediately given in awareness, and conceptualizations

of that experiencing. Gendlin accurately described the distinct bodily-felt awareness that characterizes consciousness, and which encompasses everything that we know about a given situation in a single, implicitly meaningful, bodily-felt sense. This "felt-meaningfulness" implicitly contains all the values, attitudes, memories, and perceptions relevant for the individual in the given life situation.

Gendlin realized that the essence of effective client-centered therapy was an accurate listening response that helped the client to stay closely in tune with his or her on-going process of experiencing. Gendlin also participated in the client-centered Process Scale research, which consistently found that clients who displayed a high degree of experiential focusing on immediate feelings were those who eventually succeeded in therapy. Consequently, Gendlin elaborated his philosophy of experiencing and sought ways of directly facilitating this "focusing" process in therapy. He developed the therapy procedure called "focusing" as well as principles for "experientializing" the use of conceptual knowledge in various forms of psychotherapy.

In addition to demonstrating the theoretical necessity of process variables, Gendlin implemented them as measurable variables in experimental research on therapy. A critical review of this research, which was largely abandoned by Gendlin in the mid-1960's, shows that it

suffered from serious methodological problems. Hence there is little convincing experimental evidence that "experiencing plays a central role in positive psychotherapeutic outcome." However, there are alternative philosophical and phenomenological grounds for the justification of "experiencing," and some recommendations are also made for improving experimental research on experiential psychotherapy.

INTRODUCTION

The body is wiser than all our concepts, for it totals them all and much more. It totals all the circumstances we sense. We get this totalling, if we let a felt sense form in inward space (Gendlin, 1974b, p. 236).

This dissertation is organized as a progression of four chapters. The first chapter introduces Eugene Gendlin's experiential phenomenology. The second chapter explains how this basic philosophy of human experience is instituted in the practice of psychotherapy. The third chapter outlines the historical development of experiential psychotherapy from its origins in Carl Rogers' client-centered approach, and it examines the experimental research that Gendlin conducted in support of the importance of "experiencing" in psychotherapy. This critical review of the experimental research leads to the fourth chapter, which explores the relation between experimental research and experiential psychotherapy. The contents of these four chapters are briefly summarized below:

The first chapter consists of an introduction to the basic perspective and descriptive terms of Gendlin's phenomenological approach (Section 1). Gendlin holds that human living is an on-going process of bodily-felt "experiencing" or "felt meaning." He points out that there is a distinctive, ever-present, "bodily felt" quality of any

given moment of conscious awareness (Section 2). Such "felt meaning" is distinguished from other sorts of "feeling," such as emotion, pain, or localized visceral sensations (Section 5). This experienced "felt meaning" encompasses everything that we know about a given situation in a single bodily-felt sense. In other words, "experiencing," or "felt meaning," implicitly contains all the relevant values, perceptions, memories, attitudes, and social/cultural meanings in a given life situation, and this is all "known" as it is "felt." This notion of "implicit meaning" replaces the dominating conception in psychology that posits an "unconscious mind" as a storehouse of repressed thoughts and experiences (Section 3). Another contribution of this phenomenological approach is the descriptive term "direct reference" (Section 6). "Direct reference" refers to the experienced fact that people can sometimes point to, and focus on, meaningful concretely-sensed phenomenological data, and discern significant changes in these data, without explicit conceptualizations of what these felt data are (Section 4).

Gendlin's phenomenological approach, which is grounded in a wider philosophy of life, has significant implications for theory and practice in psychology and psychotherapy. Chapter II explores how this philosophy can be translated into a systematic method of conducting psychotherapy. Specifically, it calls for a new "experiential" approach, which makes this felt experiencing process the central focus

of treatment. Gendlin has developed a general procedure called "focusing" to facilitate this crucial experiencing process (Section 7). He has also laid out how other schools of therapy can be "experientialized." This means that the theoretical concepts, techniques and methods of various therapies can be used effectively as long as these concepts are anchored in the on-going experiential felt-sensing of the individual client in the immediate moment (Section 8). Furthermore, based on his own clinical experiences, Gendlin recognized that the "essence and crux" of Rogers' client-centered therapy is a special heedful listening response--fostering responses that help the client stay closely in tune with his or her immediate felt experiencing. Gendlin focused more precisely on this responding by encouraging the constant inward checking of accurate verbal responses with the experiencing process of the client (Section 9).

Chapter III is organized as a general historical exploration of the client-centered origins of experiential psychotherapy and its supporting experimental research. Although the basic ideas of Gendlin's experiential phenomenology represent traditional issues in phenomenology and existential philosophy, the most immediate historical influence on Gendlin's psychological ideas was Carl Roger's client-centered therapy. As a doctoral student, Gendlin became interested in some of the theoretical problems that Carl Rogers faced in the mid-1950's. Rogers and his

client-centered researchers wanted to better understand and scientifically study the essential fluid nature of the therapeutic process in its full richness. This concern with change and flow in the therapeutic experience was the driving force behind the "new process conception" in client-centered theory (Section 12). Specifically, Rogers was perplexed by the paradox of how a client's feelings can change and emerge even though they are supposedly not "in" incongruent awareness (Section 12). Gendlin's answer to this problem was to introduce terms that refer to experiencing as an aware feeling containing implicit meaning (Section 17).

During the approximate period 1955-1962, Gendlin worked closely with Rogers and the client-centered movement, and he made many practical and theoretical contributions during this time. In particular, Gendlin (1962a) argued that traditional static, "content" variables of psychology cannot adequately handle the on-going process nature of human experience in therapy. Instead Gendlin demonstrated the theoretical necessity of using process variables, and he showed how they could be implemented as measureable variables in experimental research. Unfortunately, the bulk of this research suffered from serious methodological problems (Section 13).

Gendlin also contributed to the development of the "Process Scale" research in client-centered therapy (Section 14). The Process Scale methodology allowed researchers to measure the level of client "experiencing" by observing and rating tape-recorded excerpts of therapy sessions. The Process Scale ratings were based on a system of specified behavioral observations of client verbal responding. This experimental research made the monumental finding that successful cases in therapy could be accurately predicted in the earliest sessions based on their "level of experiencing" (as measured by the Process Scale). Those clients who displayed a manner of experiencing characterized by focusing on immediate feelings and felt meaning were those who succeeded in therapy. Based on these consistent findings, Gendlin became interested in pursuing the implications of the Process Scale research. In this regard, Gendlin studied whether experiential focusing is a trait or learnable skill, and began developing ways of teaching "focusing" (Section 15). Eventually, by the early 1960's, Gendlin had diverged from the client-centered movement to actively pursue the many philosophical, practical, and theoretical implications of this original guiding idea of "experiencing" (Section 16).

The fourth chapter examines the relation between experimental research and experiential psychotherapy. It establishes the vital importance of theoretical clarity about what "really" happens in psychotherapy by carefully

distinguishing Rogers' construct of "experience" from Gendlin's descriptive term "experiencing" (Section 17). Gendlin notes that most psychological theories, like Rogerian theory, lack terms that refer directly to experiencing, and lack research variables that directly measure the experiential process in therapy. In contrast, Gendlin established theoretical clarity and the need for terms that refer directly to experiencing, and he developed several viable means of scientifically measuring experiential process events (Section 18). However, it is argued that there is no strong direct experimental support for the hypothesized crucial role of experiencing in "effective" therapy because of serious methodological problems with Gendlin's experimental research.

Furthermore, there is a more fundamental problem with the basic correlational design typically used in Gendlin's studies, which severely limits conclusions about the important role of experiencing in positive therapeutic outcome (Section 18). The shortcoming of the correlational paradigm in Gendlin's experimental research is addressed. Then, based on an understanding of the strengths and weaknesses of Gendlin's experimental research (Section 19), a general experimental research strategy is suggested, which may offer stronger direct support for the role of experiencing in psychotherapy (Section 20). Finally, there is a discussion of the issue of whether the experimental justification of experiencing is necessary. It is concluded

that there are alternative philosophical and practical phenomenological grounds for the verification of experiencing as a crucial process in psychotherapy (Section 21).

CHAPTER I -

GENDLIN'S EXPERIENTIAL PHENOMENOLOGY:

A PRE-THEORETICAL DESCRIPTION OF HUMAN EXPERIENCING.

1. General Introduction.

Eugene Gendlin has been describing and researching the phenomenon of human experiencing for over twenty years. Altogether his extensive work includes over fifty published articles and books (see Gendlin bibliography), and he has offered valuable insights into the nature and study of human experiencing from several distinct perspectives:

--as a phenomenologically-oriented philosopher:
Gendlin, 1962a; 1964a; 1964c; 1965a, b, c; 1966b; 1967c;
1973a; 1973b; 1977; 1978-1979; 1982; 1983.

--as a practitioner speaking on therapeutic procedures and methods: Gendlin, 1964b; 1966b; 1968b;
1969a; 1973; 1974a; 1974b; 1975; 1978; 1979; 1981;
Gendlin and Olsen, 1970.

--as an empirical psychologist and researcher:
Gendlin, 1961a; 1962b; Gendlin and Berlin, 1961; Gendlin
and Shlien, 1961; Gendlin, Jenney, and Shlien, 1960;
Gendlin, Beebe, Cassens, Klein, and Oberlander, 1968;
Rogers, Gendlin, Kiesler and Truax, 1967.

--as an advocate of new research approaches to psychotherapy: Gendlin, 1957; 1961a, b; 1964a; 1973;
Gendlin, Beebe, Cassens, Klein, and Oberlander, 1968.

--as an advocate of new theory in psychotherapy:
Gendlin 1957; 1961a; 1962a; 1964a; 1966b; 1967a; 1969a;
1973; 1979.

--as a commentator on the profession: Gendlin,
1966b; 1968a; 1974a; 1974b; 1975; 1979; 1981; Gendlin
and Beebe, 1968a; Gendlin and Rychlax, 1970; Gendlin,
Kelly, Faulinaitus and Spaner, 1966; Bookbinder, Gendlin
and Pearson, 1963; Gendlin, Diesenhau, Oberlander and
Pearson, 1967; Gendlin and Glaser, 1973.

--as a leader in the area of schizophrenia,
commenting on: the nature of the illness and its
treatment (Gendlin, 1962c; 1966; 1972); the practice of
therapy with schizophrenics (Gendlin, 1961b; 1963a;
1964b; 1966; 1972; Gendlin and Geist, 1963); and
conducting research in the area (Gendlin 1962b; 1963a;
1966).

To some extent, Gendlin's prolific writing makes it hard to find a point of departure in presenting his philosophy and psychology. Yet his broadly based efforts center around a core of fundamental ideas. I believe the foundation stone of his approach is the notion of "experiential felt sense." In some ways, this notion seems incongruous with the usual ways psychologists view experience, but this does not mean that it is a complex conception that is difficult to comprehend. On the contrary, Gendlin has successfully communicated this perspective to laypersons untrained in philosophy or scientific psychology in his popular book Focusing (Gendlin, 1981), with self-help instructional tapes (Gendlin, 1978), and with focusing training workshops, and "Changes" groups across the country (Gendlin, 1979; Gendlin and Hendricks, 1972; Gendlin and Glaser, 1973). For Gendlin, experiential felt-sensing is not an abstract idea but rather an accurately descriptive term for the nature of immediate given experiencing. Felt sensing is something directly available to any individual, and Gendlin (1965a, 1967a) holds that its "truth" can be established by clearly beholding and adequately describing the phenomenon of experiencing. This is the aim of his experiential phenomenology (Gendlin, 1962a, 1973a).

This opening chapter will be devoted to Gendlin's phenomenological task of describing what human experiencing is like and introducing his descriptive terminology for it.

For Gendlin, this endeavor is "pre-theoretical," meaning that it is crucial to begin with a descriptive clarification of the immediate nature of experiencing before formulating theories about the structure of human personality and behavior.

2. The Concept of "Felt Sensing."

In the following quote, Gendlin describes what a "felt sense" is to his lay readers. His aim here is not to introduce "just another theory" about human behavior, which the reader could accept or reject as a new way of viewing the world. Rather, he wants to establish a convincing "pre-theoretical" description of human experiencing that the reader must acknowledge as completely accurate to his or her own experience of the world. Therefore his approach is to describe the nature of experiencing (which is common to all people) in such a way that the reader can recognize this same process in himself, and say "yes, that is how I experience the world."

A felt sense is not a mental experience but a physical one. Physical. A bodily awareness of a situation or person or event. An internal aura that encompasses everything you feel and know about the given subject at a given time-- encompasses it and communicates it to you all at once rather than detail by detail. Think of it as... a big round feeling.

A felt sense doesn't come to you in the form of thoughts or words or other separate units, but as a single (though often puzzling and very complex) bodily feeling (Gendlin, 1981, pp. 32-33).

In this quote, Gendlin is calling attention to the fact that there is a distinct and essential "bodily felt" quality in any given moment of human awareness. When he stresses the "physical" quality of a felt sense, Gendlin is emphasizing that awareness is always characterized by this ever-present singular "bodily felt" quality. For Gendlin, the "mental" ideas, thoughts, and perceptions we have are not our immediate experiencing. Rather felt sensing is the ground for any words or thoughts we may have. Words and ideas are mediate formulations arising from our immediate bodily-felt experiencing of the world. This explains why it is true that we can already know what we are going to say before we have the words to express it. At any given moment, in any situation, conscious awareness is experienced as a single aura of bodily feeling, a full and round sensation. This experiencing has a distinctive and unique "shape" at any given moment. But the shape or "meaning" of a felt sense cannot be mentally deciphered or labeled by the person, because experiencing is not a pattern or a collection of discrete units of information. A felt sense must be "met" or "allowed to show itself" via the through-the-body route which Gendlin calls "experiential focusing" (described in Section 7).

Gendlin holds that we can directly attend to our "felt sensing" in any given moment. It is always "there for us," with or without our knowing "what it is," and it is always open to formulation into explicit meaning. In other words, experiencing is an on-going process of "implicit felt meaning" (discussed in Section 3), which is the basis of our explicit words and concepts (i.e. understanding) about the world. This is noted in the following quote from Gendlin (1962a, pp. 11-13):

[Experiencing] is something so simple, so easily available to every person, that at first its very simplicity makes it hard to point to. Another term for it is "felt meaning," or "feeling." However, "feeling" is a word usually used for specific contents-- for this or that feeling, emotion, or tone, for feeling good, or bad, or blue, or pretty fair. But regardless of the many changes in what we feel --that is to say, really, how we feel-- there always is the concretely present flow of feeling. At any moment we can individually and privately direct our attention inward, and when we do that, there it is. Of course, we have this or that specific idea, wish, emotion, perception, word, or thought, but we always have concrete feeling, an inward sensing whose nature is broader. It is a concrete mass in the sense that it is "there" for us. It is not at all vague in its being there. It may be vague only in that we may not know what it is. We can put only a few aspects of it into words. The mass itself is always something there, no matter what we say "it is." Our definitions, our knowing "what it is," are symbols that specify aspects of it, "parts" of it, as we say. Whether we name it, divide it, or not, there it is... This inward referent (always this or that concrete aspect you attend to) is what I term "experiencing."

Notice, it is always there for you. It may not always be clearly definable. In fact, when you pay attention you can notice that it is really never just any definable quality or tone or content. It can always be further differentiated and further aspects of it can be specified.

This quotation provides an excellent description of what Gendlin terms "experiencing" or "experiential felt sensing," and it is used here for definitional purposes. At the same time, several important issues are implicated in this definition. These issues will be "unpacked" and addressed in subsequent sections, beginning with the notion of "felt meaning" or "implicit meaning" in the next section.

3. The Concept of "Implicit Meaning."

Gendlin (1964a) has developed the idea of "implicit meaning" as an alternative to the problematic concept of "unconscious awareness," which is presently so widespread in psychology (Gendlin, 1962a). This well-established traditional approach to personality theory postulates that there are masses of "known" thoughts and contents that are being actively repressed or blocked from consciousness. There are two fundamental mistakes with this theoretical approach, which Gendlin (1964a) calls "the repression paradigm" and "the content paradigm." The repression paradigm makes the mistake of positing experiences as contents, which are "repressed" (Freud), "denied to awareness" (Rogers), or "not me" (Sullivan). The content paradigm makes the mistake of formulating experience as

fixed discrete "contents" in the personality, whether they are called "experiences," "factors," "S-R bonds," "needs," "drives," "traits," "self-concepts," "infantile fixations," etc.

For example, Carl Rogers' personality theory illustrates the problems caused by these two traditional mistakes. Rogers defines "experience" as all the organismic events occurring within the envelop of the person at any given moment. "Experience" therefore includes those events which the individual is unaware of, as well as those which have been accurately symbolized in conscious awareness. These contents of "experience" are regarded as essentially the same in nature whether they are "in awareness" as explicit conceptualized contents (e.g., "this arousal is anger at my boss"), or "denied to awareness" because they are incongruent with the self-concept (e.g., "as a peaceful person, it is unacceptable for me to be angry"). Like other personality theories, Rogers' theoretical formulation leads to three main philosophical difficulties. One is the absurdity of positing an infinity of discrete psychological events, some of which are accurately conceptualized as explicitly known contents "in awareness," and others which are "denied to awareness" because they lack conceptualization. A second problem is how to talk clearly about experiences, which are meaningful, but which are not "known" through accurate explicit conceptualization. A third problem is explaining how "repressed" contents, which

are "unconscious" or "unformed," can be congruent or incongruent with conscious awareness.

Gendlin recognized that Rogers needed terms that refer to "experiencing" as that which in awareness implicitly contains meanings and values (see discussion Section 17). This notion of "implicit meaning" is Gendlin's alternative to the repression and content paradigms of psychology. The nature and advantages of this new approach are outlined below:

As we have seen, a "felt sense does not come to you in the form of thoughts or words or other separate units, but as a single (though often puzzling and very complex) bodily feeling" (Gendlin, 1981, p. 33). Furthermore, any given felt sense contains a wealth of implicit meaning. To demonstrate how this concept of implicit meaning works, Gendlin (1981) uses the following illustration. If you think about two important people in your life, you will notice a distinct "inner aura" that gives you a sense of "all about John," and a distinctly different aura of "all about Helen." This sense of "all about the person" is not created from discrete thoughts and impressions that are added together one by one. Indeed there are millions of bits of data that constitute John as you know him.

Gendlin points out that it is philosophically absurd to conceive of these thousands of thoughts as lurking in a hypothetical unconscious mind, waiting to be called up into

consciousness one by one. This would mean that John's red hair would not enter your conception of John as you know him until that actual thought entered conscious awareness. Instead, the sense of "all about John" emerges all at once as a single bodily-sensed aura that includes every one of those thousands of past and present experiences concerning John. In fact, Gendlin (1981, p. 34) suggests that this awesome amount of information is stored in-the-body as a kind of "biological computer." This is the meaning behind his terse saying that, "the unconscious is the body" (Gendlin, 1974b, 1979).

Gendlin (1964a) asserts that most of our "thinking" proceeds in the form of felt meaning without verbal symbolization. In other words, "experiencing" is felt (as implicit meaning) rather than known (as explicit words and concepts). At times, felt meaning may become explicit --when it occurs in interaction with designated symbols, such as words, and we "feel" what the symbols mean. But even then, felt meaning "always contains a great deal more implicit meaning than we have made explicit" (Gendlin, 1964a, p. 112). For example, even if my concept of John is explicitly symbolized as "a pleasant, easy-going scholar with red hair," there is still a wealth of implicit felt meaning "about John" that is not captured in the "contents" of this verbal symbolization. In other words, the felt sense of "all about John" is but one aspect of "experiencing" that can be attended to directly --i.e., as

it is immediately bodily-felt.

At any given moment, there are innumerable aspects of "experiencing" that can be made explicit through verbal symbolization. When an aspect of implicit felt-meaningfulness has been "explicated," the individual can feel an experiential "shift." The experience of this shift was demonstrated earlier in the self-experiment, in which the reader imagined two familiar persons in his or her life. Imagining one friend had a distinct concretely-sensed "aura" of "all about that person," and then imagining the second friend had a distinctly different "aura" of feeling. The actual bodily-felt sensation of a change in felt sensing when imagining the two different persons is an illustrative example of a "felt shift." However, the important point is that this felt change is the bodily-felt indice of a "shift" in implicit felt-meaningfulness.

This example is somewhat misleading because it is an instance of experiencing "narrowed" to felt-meaningfulness about one specific topic. More appropriately, felt-meaningfulness is about one's broader relatedness with the world at any given moment, and it implicitly encompasses all of one's perceptions, meanings, values, and history in a given situation, in a single global "feeling." "Explication" occurs when the person focuses attention on a felt meaning with the aim of opening up the implicit meaning into an explicit conceptual understanding. This sort of

"explication" is an event that commonly occurs in psychotherapy, when the client has a particular intense feeling and desires to "know" what is "in" this feeling, or what "it" means. By concentrating on the felt meaning, "selected" symbols present themselves --such as a word, or phrase, or image-- and these symbols have the power to call forth the felt meaning which selected them. When the words or symbols are considered, and "feel right" as "yes, that is what I was feeling," then we regard these words as having explicated the implicit meaning in the felt experiencing. As this process occurs, there is a bodily-felt "shift," which indicates that some aspect of the implicit meaning of the felt sense has been differentiated and carried forward.

At the same time, the specific aspect of the felt sense which has been explicated should not be viewed as some sort of "thing" resting inside the person prior to its re-presentation in explicit words: for example, positing "John's red hair" as a "content" in the mind, which can then be represented in these exact words. Such a view would revert to the mistakes of the content and repression paradigms, which hold that there are contents or entities stored in the "unconscious," which have a one-to-one correspondence with conceptual contents in conscious awareness. On the contrary, a felt sense is richly complex in its implicit meaning. Thus there are a multitude of meaningful aspects of a given felt sense which could be potentially differentiated; and there are no set words or

conceptualizations that symbolically represent or "stand for" designated inner subjective events.

In other words, experiencing is capable of many different formulations, but it is never itself the explicit contents of any particular verbal symbolization. Experiencing is a felt sensing of an aura of felt meaning about a situation rather than a cumulative collection of discrete thoughts about the constituent elements of that situation..

Finally, a felt sense can often be explicated in ways that do not involve symbolization. Explication is the "explication of" felt-meaningfulness such that something happens that carries forward, or opens up, or differentiates the meaning that functions implicitly in the felt sense. Frequently this explication occurs through symbolization, but not always. Therefore symbolization is only one way to "explicate" the process of experiencing. There are also occasions when symbolization --such as verbal conceptualization-- fails to explicate the felt meaning that functions implicitly in experiencing (i.e., felt-meaningfulness). In order to understand how some acts of symbolization do explicate experiencing, while other symbolizations do not, it is crucial to further clarify what "experiencing" is like and how it is "explicated." This issue is addressed in the following section.

4. Experiencing Distinguished from Formulations of Experiencing.

In review, "experiencing" is an immediate, bodily-felt process of felt-meaningfulness, continually flowing and changing in response to the changing circumstances of living. The felt experiencing of any given moment implicitly contains and encompasses the wealth of all the perceptions, values, past experiences, and meanings involved in the given living situation for the individual at that moment. Experiencing is felt as implicit meaning rather than known as explicit conceptualized words and thoughts. However, at times, aspects of an implicitly meaningful felt sense can be made explicit through explication.

"Explication" occurs when symbols have "called forth" or "opened up" the felt meaning of experiencing such that this meaning has been clarified in awareness. "Explication is always a further process of experiencing. It carries forward what we already feel" (Gendlin, 1965a, p. 132). This quote emphasizes the close dialectic relationship between experiencing and explication: the felt-meaningfulness of experiencing is carried forward by explication, which then effects and changes the felt-meaning quality of experiencing, which then calls for further explication, and so on. The two processes are so intimately related in this manner that it is problematic to discuss

them as being separate. This is analogous to the way mind and body are distinguished in modern Western thinking, although they are not separable in reality. However, for the present purposes of further defining the notion of "experiencing," it is instructive to distinguish between experiencing and formulations of experiencing. This conceptual dualism is used in the following discussion precisely to clarify and define experiencing for an audience that is unfamiliar with Gendlin's phenomenological approach. But this distinction has been prefaced by the cautionary reminder that there is a dialectic relationship between experiencing and explication.

The phenomenological datum refers to that which is immediately and directly beheld in awareness. This can be distinguished from symbolization, which is the terms, patterns, or units that are used to describe, represent, or point to the phenomena of this awareness. It is crucial to understand this distinction between the phenomenological datum and the formulations that are placed upon this datum. However, it is difficult to grasp this distinction because of the usual ways in which psychologists view subjective inner events. Gendlin (1965a) points out that direct felt experiencing has two properties that are independent of the formulations that are placed on it: powers that he calls "independent access" and "response." These two properties provide an immediate demonstration of the fact that experiential felt sensing always constitutes the ground of

our words, ideas, and thoughts.

Independent access means that we frequently can sense and feel an inner datum without having any explicit formulation or conceptualization of it. For example, one can "know" what one is going to say without reciting any words or ideas of it. Or one can feel that something is "out of place" long before one can specifically identify what this awkward feeling is. For example, a hurried commuter might be departing his house and knows that something is "not right." Several minutes later, he realizes that his "not-right feeling" involved the lunch he forgot to bring. Similarly, thinking of a person that you know well is characterized by an aura of "feeling about that person," but the exact "contents" of that aura remain "unknown," implicit in that felt sensing.

The second power of immediate experiencing is called "response". This means that we can directly sense how what we are feeling "responds" differently to different symbolizations in words, actions or events. We can "inwardly" perceive when there is any change or shift in felt sensing in response to a particular conceptualization. For example, the hurried commuter can tell that his "not-right feeling" was not "leaving the stove on," or "failing to feed the cat," and then know with certainty (with a bodily-felt "shift") that "it" was forgetting his lunch.

Before proceeding with this discussion, it is important to first say a few words about the interaction of symbols and experiencing. Obviously symbols do not "float around" in some haphazard fashion, waiting to interact with experiencing. Symbols always occur in a meaningful context, such as a conversation, or a particular social event, or in psychotherapy, or walking on the beach. For instance, the hurried commuter considered several symbolic formulations that were appropriate in the context of "leaving for work": it was possible that his feeling was about forgetting the hungry cat or the burning stove. But his felt meaning was not about how to spell "xylophone" since this was not a part of the meaningful context encompassed in his immediate felt sensing of that moment.

In some cases, symbols arise from the felt sense itself and can function as its explication. At other times, symbols may be applied by another person, such as a counselor, in reference to another's inner subjective state. There are innumerable ways that symbols can interact with felt experiencing. However, regardless of the "source" of the symbols, we can directly sense how our felt meaning responds differently to different symbolizations.

In summary, the two properties of "independent access" and "response" demonstrate that experiencing can be distinguished from symbolization and formulations of experiencing. We can have independent access to felt

meaning, such as "oh, there it is," without a conceptualization of what "it" is. Moreover, we can inwardly sense to what degree "that is it," or "that's not it" in "response" to various potential symbolizations, such as "it" is leaving the stove burning, or forgetting one's lunch.

With this in mind, we now understand that what psychologists usually conceive of as "experience" is actually symbolization-- formulations of experiencing. Psychologists make the mistake of equating conceptualizations of experiencing with experiencing. For example, "feeling anxiety about personal failure" or "desiring to change careers" is not direct experiencing itself. It is only one way that experiencing might be explicated in this given moment, and it represents only one aspect of an entire complex of implicit meaning encompassed by the felt sense. These particular words, ideas, and thoughts may seem to be what is immediately experienced by the person, but experiencing is never just this or that formulation. Experiencing always contains much more meaning than what is explicitly formulated as designated words or ideas, such as "feeling anxiety about failure."

Gendlin (1962a) points out that this is a common error because psychology lacks terms that refer directly to immediate experiencing (see Section 17). Present terms in psychology either (1) refer to externally observable

behavior, or (2) they are theoretical constructs without observable referents at all. In other words, terms like "anxiety," "security," "self-concept," and "inferiority complex" seem like they are referring to direct experiencing, whereas in fact they are actually conceptualizations (constructs) of experiencing.

Experiencing and conceptualizations of it can occur together, or separately. But the fact that experiencing and conceptualization are different is most noticeable when they do not occur together-- e.g., those occasions when we have experiencing that we cannot conceptualize, or when we have conceptualizations that "don't feel quite right." Gendlin points out that this is a very common event in psychotherapy (see Gendlin, 1962a, pp. 117-127 and 233-235). Clients often find it difficult to find words for intensely felt experiencing, and they can immediately tell whether a proposed conceptualization "carries forward" the unclear feeling or not-- "yes doctor, that's exactly it," or "no, that's not quite what it is."

We can further define experiencing by introducing an example of how experiencing might be explicated. As an instance of direct experiencing, suppose that at this moment in time, I have a felt sense. Initially, this felt-meaningfulness is a "whole" feeling that implicitly encompasses everything "all about" this present situation in life for me. I know that this feeling is my direct

experiencing because this felt sensing has the two defining powers of independent access and response. First of all, "independent access" is demonstrated by the fact that I have this felt sensing of some phenomenological datum without any present conceptualization of what "it" is. Then the process of explication begins when I direct my attention to this felt sensing. As a result of this attending, I become aware that this felt sense has been narrowed to a felt sensing of "something" as yet "unknown" to me. I can sense that "something is there," that "there it is." As yet, I have no explicit knowledge of what the felt sense "means," but I have employed verbal symbols (such as "there it is") to point to, or refer to this particular datum. This is a type of formulation of experiencing called direct reference (see Section 6), and the phenomenological datum which I can "refer to" is called a "direct referent" (Gendlin, 1964a). In turn, this direct reference has changed the "shape" of my felt sense, focusing it so that I feel it more intensely.

Next, as a result of attending to this intensely-felt referent, conceptual symbols present themselves from the felt sense. At first, I realize that my felt sense is "about something that disturbs me." The property of "response" is demonstrated here by the fact that I can directly sense shifts in my experiential felt sensing as a function of (in "response" to) various symbolizing ideas: initially, I sense no bodily felt shift to the idea that "perhaps it is about Helen," while I do feel a distinct

change in this felt datum with the explicating idea that "it is about John." Thus an aspect of the felt experiencing has been first explicated through direct reference-- "I sense a something"; and then further explicated through conceptualization-- "this is a sense of something about my friend John." The various ideas and memories that I subsequently have "about John" may then represent further steps in the on-going process of explication of this given moment of experiencing. In other words, explication is a process of making various aspects of "implicit meaning" explicit. At the same time, the explication furthers the process of experiencing, "carrying it forward," opening up new aspects of felt-meaningfulness for explication, and so on. It is not a process of finding labels for what was "lying there" already. Eventually, I may find that John's broken promise is an aspect of "that something" which I directly referred to in the beginning. I may then proceed to explicate further implicit aspects of this particular instance of felt sensing, whose felt shape has been continually changing through-out this process as it was referred to and explicated.

In the above example, it is clear that my experiencing is always "ahead of my concepts," and "guides" my conceptualizations. As I formulate concepts or hypotheses about my experiencing, I can "check them against" my felt sensing. In other words, if I consider these symbols and they "feel" the same as the felt meaning I endeavored to

explicate, then I recognize that the felt meaning has been called forth and explicated.

But felt meaning should not be conceived of as some sort of static entity, which words and concepts can be "fitted to." This misconception commits the mistakes of the content and repression paradigms, which posit psychological contents that are "denied to awareness" until they are accurately conceptualized as explicit contents in conscious awareness. In this view, symbolizations are "fitted to" static contents in the mind in a "re-presentational" fashion.

The explication of experiencing is a very different process. Here selected symbols call forth some aspect of the implicit meaning in felt-meaningfulness, but not by correctly symbolizing some content already "lying there" to be symbolized. Rather, in explication, symbolization is recognised as "correct" when the felt meaning resulting from the explicit symbolization feels the same as the felt-meaningfulness I attempted to explicate. This is the bodily-felt experiential effect of differentiating some aspect of experiencing and carrying forward this aspect of its implicit meaning. In turn, the explicating process furthers experiencing, opening up new aspects, affecting its felt quality, and carrying forward "that which" is contained in the implicit meaning of the felt sensing.

Thus, in explication, the "correctness" of conceptualizations is determined on the basis of felt changes or "shifts" in my felt sensing. An "incorrect" or inadequate conceptualization produces little or no discernible shift in bodily-felt sensing, while more accurate conceptualizations produce distinctive positively felt changes in sensing. For instance, when I thought of Helen, there was no felt effect. But when I thought of John, I "knew" --based immediately on my felt response-- that "that was it." Subsequently, if I thought of "the money John owes me," I may have sensed little shift. But when the idea of John's broken promise arose from the felt sense, I knew with certainty "that was it."

Clearly then, not all conceptualization functions as explication. Conceptualization of experiencing is "explication" only when it is an explication of immediate felt-meaningfulness that differentiates and carries forward experiencing. Conceptualization is not explication if it merely labels an experience without referring to immediate felt meaning. Hence, the same verbal symbols that explicated experiencing in one situation may not function as explication in a different situation, or even in the same situation a few moments later.

Furthermore, when a particular conceptualization carries forward some aspects of a direct referent, the person usually senses the felt meaning more vividly. There

is a "shift," a pleasant feeling of easing and relief of tension when felt meaning is explicated. This experience of tension-relief as a function of direct reference to, and explication of, felt meaning has important implications for psychotherapy. In his own clinical work, Gendlin (1964a) has pointed out that even when experiential focusing involves personally painful topics, the process of directly focusing on a felt meaning (i.e., the direct referent) produces positive feelings:

A very important and surprising fact about direct reference to felt meanings is that if the matter under consideration is anxiety producing or highly uncomfortable, this felt discomfort decreases as the individual directly refers to the felt meaning. One would have expected the opposite... Thus, [the client] may be in quite a lot of inward pain as he decides to bring the matter up at all. However, once into the topic, the more directly he attends to the direct referent, the felt meaning, the less his discomfort and anxiety. If he momentarily loses track of it, the anxiety flares up again, and the diffuse discomfort of the topic returns...

In contrast to the anxiety or discomfort, the felt meaning itself becomes sharper, more distinctly felt, as he refers to and correctly symbolizes what it is. In fact, his sense of whether or not he has "correctly" symbolized is partly just this sense of increased intensity of the felt meaning.

This decreased anxiety is a very surprising fact, much against the general assumptions about anxiety-provoking material. We generally assume that to focus directly on the experiencing makes us more anxious. My observations indicate that increased anxiety comes from topic choice, and it is this which we generally expect. On the other hand, given the topic, the more we focus directly upon the felt meaning, and the more of it we symbolize correctly, the more relief we feel. Even a little error in symbolizing ("no, what I just said isn't quite it") again increases the anxiety (Gendlin, 1964a, pp. 116-117, latter italics added).

Despite Gendlin's claims, it may still seem contestable that recognizing some horrible "fact" about oneself can feel physically good. However, it is crucial to understand that symbolization is not just a process of finding an explicit label for a horrible "fact" about oneself. In Gendlin's view, there is no static entity of experience, no horrible "fact," that is "lying there" inside, and which is then "symbolized correctly" and it feels good. This is not explication, it is merely conceptualization. As the quotation emphasizes, the positive feelings of tension-relief arise from the manner in which the individual directly refers to the felt meaning: "the felt meaning itself becomes sharper, more distinctly felt, as he refers to and correctly symbolizes what it is." Clearly then, symbols are not applied to a felt sense as if it was a static thing. Symbols flow from the felt experiencing itself when it is directly referred to, and these symbols can then call forth aspects of the felt-meaningfulness and carry it forward. In other words, correct symbolization emerges from the on-going process of experiencing and the explication of experiencing.

For example, suppose you are feeling "uneasy and irritable" after dinner in a restaurant, and do not know why. Being told that you are a "cheapskate," and realizing that it is probably true, is very unlikely to yield a good feeling of tension-relief. In this instance, the explicit recognition of "what you are feeling" is not characterized

by relief of tension. Gendlin would argue that there is no felt relief here because this is not an explication of experiencing. Being called a negative name like "cheapskate" --without reference to the on-going process of experiencing-- is an example of "mere conceptualization" that does not explicate. This is a crucial distinction. Recognizing "bad" content per se does not "feel good." It is the manner in which the "bad" content is experienced that determines whether there will be an experiential shift and a bodily-felt relief of tension.

Although the direction may seem deplorable to [the individual], he feels unquestionable relief as he differentiates. It is as if he is so glad to know, at last, what the feeling is. However, it isn't really a gladness at knowing, since, if he had been told this piece of knowledge without the concrete differentiation's having occurred, he would not have felt at all glad (Gendlin, 1967b, p. 186).

In short, being "told" you are a cheapskate hurts if this content does not directly emerge from the on-going process of experiencing and the explication of experiencing. On the other hand, if you have allowed a felt sense to form, and this conceptualization emerged directly from that felt sense, and it "carries forward" the felt meaning of that direct referent, then you may feel the tension-relief of an "experiential shift." This felt shift in experiencing marks the freeing up of "stuck" life processes. They became "unstuck" through experiential focusing and explication of this implicitly meaningful experiencing.

As a closing note, the reader may wonder whether there is any empirical evidence to support Gendlin's assertion that experiential focusing on a painful topic can be experienced as positive tension-relief. For the most part, Gendlin's rationale for this claim is philosophical, grounded in his broader systematic phenomenology (Gendlin, 1962a). But there are two sources of supporting empirical evidence. First of all, Gendlin's claim that direct experiential focusing on "bad" content can bring tension-relief is based on his own clinical experiences. Hence there are empirical clinical and "testimonial" grounds for this claim. Secondly, there is a small bit of experimental support for this observation about therapy. Two experimental studies have suggested that there are demonstrable physiological correlates of tension-relief during experiential focusing on "bad" content (Gendlin and Berlin, 1961; Don, 1977-1978). For example, in a laboratory analogue study, Gendlin and Berlin (1961) found clear tension-reduction patterns on a GSR measure, which corresponded to instances of direct reference to experiencing involving "disturbing content" (discussed in Section 13).

5.- Felt Experiencing Distinguished From Other Types

of "Feeling" Such as Emotion and Pain.

The fundamental notion of experiential felt sense can be defined more clearly by carefully distinguishing it from "emotion." In a few words, although feeling and emotion are both "felt," felt meaning constitutes the ground of any particular emotional state. A felt meaning is internally complex and the individual can feel this direct referent changing as a function of focusing attention on it. But emotions are "sheer" in the sense that emotions are "internally all one quality," and they are "about" the direct referent.

Suppose an individual feels the emotion of anxiety. It is a strong uncomfortable sensation, but the actual "emotional core" of the anxiety does not change in an essential way without either disappearing or changing into another emotional state. To remain with the emotion serves only to feed the emotion. When the individual is preoccupied with the emotion of anxiety, he or she is often confused about the felt meaning about which he or she has the anxiety. In a sense, he or she must move "on by" the emotional core in order to refer directly to what the anxiety means, and to focus on what it is that makes him or her feel anxious. In this way, the individual can directly refer to the felt meaning in the on-going process of experiencing, and he or she can sense distinct changes in

felt meaning even though the emotional tone of the anxiety has remained essentially unchanged. [The word "tone" is used here to emphasize the sheer, singular quality of an emotion. It is directly analogous to a musical tone, which is simple and singular in quality, and sounds the same each time it is sounded. Though the musical tone may vary in intensity with repeated execution, the tone remains essentially unchanged in quality. In contrast, a musical piece is a complex blending of many musical "tones," whose quality changes dramatically as a function of multiple contributing sounds.]

Furthermore, when the individual distinctly feels a change in the quality of the felt referent, it is a "movement" or "shift" which feels right and welcome. Thus while the individual is in the "sheer" emotional state of anxiety, the individual can focus on a variety of felt meanings that are "inside" or "beneath" the anxiety. For example, the focusing person may say: "I feel this anxiety when I think of my job... There 'it' is again, that sense of helplessness, like I'm a baby... It feels like I've no one to hold me, like I felt when my wife died..." These statements represent a succession of conceptualizations that might elicit a felt change or shift as a function of symbolizing and carrying forward some aspect of "that which" the individual is anxious about. But the tonal quality of the person's anxiety itself never changes, except to increase or decrease in intensity.

Some psychologists might try to debate Gendlin's position by claiming that we cannot focus precisely on our inner sensations. For instance, the behaviorist Howard Rachlin (1980, p. 54) says that "our internal sensibilities are crude, whereas our external sensibilities are precise." Rachlin suggests that there is little distinction between internal states such as pleasure and joy, and that we probably cannot make such a distinction based on our inner sensibilities alone. For example, "we often cannot tell which tooth is causing a toothache or whether a pain is in our stomach or back." In contrast, Rachlin notes that we can make delicate discriminations among external factors, such as detecting the misalignment of two lines by as little as a fraction of a millimeter. Therefore Rachlin concludes that external situations determine how people label their internal states. This position is certainly consistent with Skinner's own view of the (delusive) "apparent intimacy of the world within the skin" (Skinner, 1976).

However, for Gendlin, this entire argument is fundamentally misdirected and misconceived. An experiential felt sense is never merely some specific twinge or pain that is traceable to a specific physical location "inside" the body. As we have seen, a felt sense is experienced as an aura of feeling that encompasses everything you feel and know about a given subject at a given time. It is experienced as a round, broad feeling that comes all at once. It may often be vague in that we may not know "what

it is," but it is definitely sensed in a concrete way. On the other hand, a pain or internal stimulus like a hunger pang is distinctively "narrow" and specific, and in principle can be traced to a physical location in the body. It certainly is not an ever-present quality of the felt-meaningfulness that constitutes human conscious awareness. While pains and twinges can come and go, any given moment of awareness always has felt sensing. The only similarity between all these phenomena is that they involve feeling of some kind. But there is no similarity in the essential character of that feeling.

For example, suppose you feel a hunger pang. You can feel it in your belly, and you can hear the growling noises accompanying that stimulus. While this twinge is in your awareness, such a sensation does not constitute all of your awareness (unless it is some rare excruciating pain). At the same time that you are feeling the hunger pang, you probably also have a distinct felt sense about this situation in which you are having the pang. Perhaps it is a big round feeling of "all about going out to eat with a friend." This felt sense is quite distinct from the simple hunger pang in your stomach. The felt sensing is sort of "all over" the body, literally like an aura.

An experiential felt sense is never "just" a twinge or hurt that can be traced to some localized region in the body, such as a growling stomach or sharp pain in the spine.

Like emotions, these sorts of stimulus sensations and pains are "simple" in the sense that they are of one constant tone. A pain in the back may fluctuate in intensity, but it is of one characteristic tone that will remain essentially unchanged by "concentrating attention on it." Similarly, focusing on one's hunger pang does not change the way this pang is "felt." But thinking about one's felt sense of "eating with a friend" does change one's feeling about the situation.

Thus, in contrast to emotional states and internal bodily stimuli, a felt sense is complex. This means that aspects of the felt mass or aura can always be further differentiated into other felt meanings. However, a pain or twinge is simple, "sheer" in its tonal quality. There are no further aspects of it that can be specified. Concentrating on a hunger pang will not draw out any additional embodied meaning from the felt pang. It will only increase your awareness of the pang itself. Similarly, if you just stubbed your toe, the pain has a sheer quality until it subsides. Concentrating on the pain does not change the pain, it will only make it more precisely sensed (and more painful!) in your awareness.

Furthermore, this quality of "sheerness" would hold true for pains and visceral sensations that are more accurately portrayed as states of general physiological arousal, or as complex, broadly-dispersed emotional

reactions. Thus, for example, the arousal pattern may be "complex" in terms of involving many sophisticated interactive bodily and neural systems, or "complex" in its relations to cognitive, behavioral and situational factors. But the actual experienced tonal quality of the arousal will be simple, all of one physical texture. Obviously then, the "complexity" of emotion is of a different order than the rich, implicitly meaningful, "complexity" of a felt sense.

In conclusion, it is a misdirected strategy to conceive of a felt sense as a sensation that can be traced to a specific location "in the body." For the same reason, it would be misdirected to search for some neuro-physiological basis for a felt sense in the same way that investigators have pursued neural bases for emotion and pain. For instance, in the field of emotion research, investigators have long been concerned with the respective contributions of the interacting cognitive, physiological, and bodily aspects of emotional experience (Mandler, 1979). In this regard, emotion researchers have been interested in individuals suffering from spinal cord injuries, which have left major portions of the viscera and nervous system paralyzed. By measuring the altered quality of emotional experience following the reduction of the physiological component, one can make inferences about the contributing role of physiology to emotion. Actually this notion originated with William James, who felt the "experimentum crucis" for his theory of emotion would be an "anaesthetic

person" with no visceral perception (James, 1890, 1894). Decades later, modern researchers have asked patients with spinal cord lesions about the intensity and quality of their emotional life following the injury. They have found that the higher the level of spinal cord damage, the greater the reported loss of emotion (Hchmann, 1966; Jasn0s and Hakmiller, 1975). From this, researchers were able to infer the importance of visceral feedback in the production of emotion.

As a closing note, I would suggest that this research approach could be used to provide an informal illustrative demonstration of the distinction between felt experiencing and "felt" emotion. Using the same paralyzed subjects, two outcomes should be expected: (1) Subjects should report a decline in intensity of emotional experience following massive bodily paralysis. (2) The same subjects should report no change at all in the essential experiential felt sensing of conscious awareness.

6. The Concept of "Direct Reference."

Perhaps one of Gendlin's most important contributions to the theory and practice of psychotherapy is the notion of "direct reference." During his early years in the client-centered orientation, Gendlin was intrigued by the fact that patients very frequently would respond in ways that showed they were distinctly aware of meaningful bodily-sensed feeling, even though they lacked words to label this feeling. Often a client would vociferously report that "that's it," or "that's not it," or "I can really feel it," despite the fact that he or she did not yet know what "it" was. The term "direct reference" was first introduced by Gendlin and Zimring (1955) to describe this vitally important phenomenon in therapy.

For Gendlin, direct reference is but one of seven basic modes in which symbols and felt meanings function together in "the creation of meaning" (for a complete discussion, see Chapter 3 of Gendlin, 1962a). Symbols are words, images, persons, behaviors, situations, objects, or anything that can play the role of a symbol. Symbols function quite differently in direct reference than in the other modes. In direct reference, symbols do not function to conceptualize or label aspects of experiencing. Instead, verbal symbols such as "this," or "that," or "it," serve only to "point to" and "hold onto" a particular felt meaning. Thus the felt meaning of any given moment of experiencing is already meaningful independently of the symbols used to refer to that felt sense. Thus, on one hand, the given felt meaning

"needs" the referring symbol to "mark it off as a referent." On the other hand, the referring symbol (such as the word "this" or "that") depends entirely on the felt meaning to which it refers for its meaning.

Gendlin's idea of "direct reference" had important implications for the practice of psychotherapy because it held that positive therapeutic growth was characterized by shifts in felt experiencing, rather than clearly articulated insights or conceptualizations of subjective feeling. If this was indeed true, the very nature and purpose of psychotherapy needed to be rethought. As noted by Gendlin, most therapies concentrate on helping the client to find words for his or her feelings in order to gain insight --i.e., "accurate conceptualizations" of experience. This basic approach is based on the content and repression paradigms (see Section 3), which conceive of inner experience as entities or contents that can be accurately labeled as this or that thing, and then brought into awareness.

In contrast, according to Gendlin, the primary aim of therapy is to refer to and remain in direct contact with the client's immediate "experiencing." In this manner, the rich implicit meaning of the felt sense is allowed to unfold and open up. Consequently, the act of conceptualizing the client's problem is therapeutic only to the degree that it "explicates" or "carries forward" aspects of

felt-meaningfulness. As we have seen, experiencing is always "much more than" this or that explicit conceptual content. Other therapies have the tendency to equate conceptualizations with "that which is being immediately and directly experienced." This can freeze experiencing as static content rather than facilitate its process of ever-changing implicit meaningfulness, which is known as it is "felt."

In the following quotes, Gendlin is arguing against the dominant view among clinicians that (1) denies or ignores that there is such a therapeutic phenomenon as "direct reference," and/or (2) holds that all significant moments of progress require conceptualization:

Change in therapy does not concern only those few conceptual meanings which the individual thinks or puts into words. Therapeutic change occurs as a result of a process in which implicit meanings are in awareness, and are intensely felt, directly referred to, and changed, without ever being put into words (Gendlin, 1961a, p. 239, italics added).

Direct reference ... can occur alone. For example, a client says, "this feeling, that I have now, puzzles me." This is not a conceptualization. The client refers directly to something concretely given in his field. The symbols "this feeling that puzzles me" conceptualize nothing for him...

It is vitally important to the client that both he and the therapist refer directly to the client's feeling, whether this be conceptualized congruently or not. Recall the example of the client, who, after much use of certain concepts, has arrived at the actual experiencing that these concepts "really" meant (Gendlin, 1962a, p. 263, italics added).

A moment of concretely felt living in interaction contains many, many potential meanings --and resolutions of problems-- and not all of these can, or need be, conceptually insightfully symbolized (Gendlin, 1962b, p. 40, italics added).

First of all, Gendlin is making a crucial distinction between (1) direct reference to experiencing, and (2) conceptualization, in the process of effective therapy. More importantly, Gendlin is asserting that psychotherapy should concentrate on grounding its work in the immediately given, bodily-felt process of experiencing. He points out that both the client and the therapist can refer directly to the client's felt experiencing with and without conceptualization. At times, as in "direct reference," it is possible to attend directly to a given felt sense as it is immediately and directly felt in awareness, without "putting this feeling into words." For Gendlin, it is vitally important to "really live" experiencing as it is occurring in therapy, rather than try to find words to identify "what it is." Experiencing is meaningful living--encompassing "all that" which is meaningfully related to the individual interacting with his world, and communicating it in a single directly-sensed "feeling." Thus deeply feeling this experiencing --which is accomplished through direct reference to experiencing-- is like living life more fully, and serves to bring more life meanings to bear in therapy. For Gendlin, this rich living process is the real basis for therapeutic change.

Frequently this process is facilitated through explication-- that is, when aspects of this rich experiencing process are formulated into explicit conceptualizations that carry forward the felt-meaningfulness. However, words and symbols can sometimes be used in a manner that is not in reference to (i.e., in direct contact with) the implicitly meaningful, rich ground of experiencing. This is "mere" conceptualization that is not explication. It brings no genuine therapeutic change because "that which" has been conceptualized is not "that which" immediately and fully constitutes the individual's problem as it is presently felt. Thus, this sort of conceptualization changes nothing in terms of the stuck life processes that constitute the clinical problem. This important difference between conceptualization that is explication, and conceptualization that is not, was discussed earlier in Section 3. However, Gendlin is not claiming that therapeutic change always occurs without conceptualization, simply that it can occur, as in direct reference.

In summary then, a client can focus on a "direct referent" --an inner-sensed experiential datum-- and may puzzle over what an odd sort of "this" he is talking about. Yet there is nothing at all vague about the definite way he feels it and engages in this process. The "it" is vague only conceptually because the client can clearly attend to it, talk about it, point to it, feel its special qualities,

and feel it changing in response to words and events. We will return to this central issue in a later section on the therapeutic use of concepts in relation to experiencing (see Section 8).

Finally, it is useful to note that Gendlin has tried to demonstrate experimental evidence for direct reference. This involved first showing that direct reference could be measured operationally as a variable, and then correlating the amount of direct reference with positive outcome in therapy (see Gendlin, 1961a, discussed in Section 13).

CHAPTER II -

THE THEORY AND PRACTICE OF EXPERIENTIAL PSYCHOTHERAPY.

The opening chapter of this dissertation examined Eugene Gendlin's phenomenological description of "experiencing." The second chapter will explain how this description of human experiencing can be translated into a valid systematic approach to psychotherapy.

7. The Procedure of Focusing.

"Focusing" is Gendlin's term for the process by which individuals can gain a fuller sensing and richer understanding of their experiencing (in therapy as well as in daily living). Focusing also refers more specifically to a general procedure for attending to a felt sense and waiting for meaningful messages to emerge from the felt sense. The goal of this section will be to describe this focusing procedure.

To begin with, Gendlin's basic aim in psychotherapy is not to "cure" the individual, nor to "fix the problem," nor to "reconstruct the personality." Rather, successful therapy is characterized by teaching clients to become efficient

"focusers." During the course of therapy, clients learn to "focus" and can eventually engage in this activity without the necessity of a professional psychotherapist. In this way, clients can depart from the therapeutic relationship with the capacity to handle present and future difficulties on their own by using experiential focusing. Although Gendlin was initially uncertain (Gendlin, et al., 1968), he is now convinced that effective focusing can be successfully taught (Gendlin, 1978, 1979; McMullen, 1972; Platt, 1971; Van den Bos, 1973).

In fact, the focusing procedure has been used successfully with children (Rainsford, 1977); schizophrenics (Gendlin, 1972; Siirala, 1964; Hinterkopf and Brunswick, 1975; Hinterkopf, 1977); borderline personality types (Gray, 1976); retardates (with some modification of the procedure, Prouty, 1976); and children with learning disabilities (Murray, 1978). Furthermore, experiential focusing has been applied to other areas of living "beyond" psychotherapy, such as job interviewing in business (Iberg, 1978); dance and body movement (Alperson, 1974); spirituality (Campbell and McMahon, 1979); self-healing (Olsen, 1978); creative writing (Porine, 1977); problem-solving (Kantor and Zimring, 1976; Zimring and Balcombe, 1974); dreams (Hendricks and Cartwright, 1978); and meditation (Weiss, 1978).

Although Gendlin has developed a distinctive procedure that people can use to "focus," focusing itself is not "necessarily" restricted to any set procedural steps or conditions. In fact, Gendlin denies that any procedure can be precisely laid out as "the" definitive method of focusing for several reasons. First of all, focusing is grounded in the on-going, open process of experiencing, which is never "just" this or that static event, or act, or outcome. Focusing functions in the on-going flow of felt experiencing, which is implicitly meaningful and ever-changing. To artificially separate experiencing into specific intentional acts with fixed procedural rules would constrain this vital flowing process. Secondly, the experiencing of every individual is entirely unique to that individual in any given moment. Hence there are an infinite variety of ways that people can point to, differentiate, refer to, focus on, and explicate their experiencing. Thus individuals may use words, or poetry, or imagery, or musical inspiration, or dancing, or any variety of means to "do" experiential focusing. Thirdly, focusing is not something limited to resolving problems in a psychotherapy setting. Having a problem may sometimes be the catalyst for focusing, but not always. Focusing is basically just a way of using experiencing as a guide for living. "A moment of concretely felt living in interaction contains many, many potential meanings --and resolutions of problems" (Gendlin, 1962b, p. 40).

For these reasons, Gendlin emphasizes that there is no specific or preferred method of focusing. However, with these cautions in mind, it is possible to describe a general procedure that has been developed to facilitate experiential focusing. I will be presenting the focusing procedure outlined in the first 1978 edition of Gendlin's book, Focusing, which conceptually divides focusing into six movements. It should be remembered that there are no inherent units or defined steps into which the focusing process can be divided. Thus, although the process itself can be described as involving distinguishable aspects or movements, there is no particular set number of movements or steps in the process. Gendlin has described several different variations of the focusing procedure, all of which share the same basic pattern. For instance, in his earlier work, Gendlin described focusing as involving four steps (Gendlin, 1964a), or as requiring three preliminary conditions (Gendlin, 1969a). Moreover, variations on the general instructions for focusing can also be found in The Focusing Manual (Gendlin, 1969a; 1979; 1981; Gendlin, et al., 1968) and the Rap Manual (Gendlin and Hendricks, 1972). The following description is only one version of the focusing procedure, which I have selected for the purpose of illustrating the focusing process in general.

The First Movement of focusing is called clearing a space. Here the person endeavors to relax quietly and make himself or herself comfortable. This is a time to "set the

stage" for focusing, so to speak. To begin, the person allows all of his or her present problems to rise up-- problems such as hassles with the in-laws; mechanical problems with the car; annoyances at work; squabbling with one's spouse; or whatever. The person tries to mentally list everything that is preventing him or her from feeling contented right now. Then he or she "stacks" all these problems to one side, granting himself or herself some time away from these troubles. Obviously, this is not an act of forgetting or denying one's problems. It is simply one way to temporarily "clear a space" amidst these problems so that the person can then focus on his or her immediate experiencing. Although this experiencing may or may not include some or all of these problems, it is never merely this or that specific problem.

The Second Movement is called feeling for the problem. With all his or her problems temporarily stacked to the side, the person can now "ask" himself or herself which problem "feels worst," or which is "most pressing" right now. It is crucial to avoid any intellectual choosing of which problem should be most important to work on. In fact, the person is directed to shut off all the "internal static" of self-talking, self-lecturing, cliches, analyzing, theorizing, and do's and don't's. Rather than intellectually hunting for the problem, the person gropes for the felt sense of the problem "through-the-body." The person must allow the felt sense to come in its own way. The focuser's

aim is to get down to a single feeling that encompasses the whole problem. It will be a large, vague, formless aura, a sense of "all that." And though it lacks words and details, it is concretely sensed as a whole, single, felt sense. It is analogous to listening to a symphony and feeling the effect of the entire orchestra as a single immediate whole of musical sound. It is unnecessary to know the details of the multitude of notes contributed by each separate instrument. The full and total effect of the symphony comes to you as a whole without discrete units or details. In the same way, the second movement of focusing is like trying to avoid becoming distracted by the horns or the violins, and instead allowing the symphony to be experienced as a whole singular effect.

The Third Movement of focusing is called finding the crux. Having contacted the felt sense of "all about ...", the person now asks for the crux of the felt sense. In "asking" this question, the person deliberately refrains from trying to answer it with intellectual problem-solving. It requires waiting for the crux to come from the felt sense itself. The person finds he or she can "communicate" with his or her own felt sense without any words, ideas, or labels. It is concretely felt through-the-body as "there it is" even though the person does not yet know "what it is." At this point in the process of focusing, people often feel the first "shift"-- a sensation of internal movement that says "that is it," or "this is right."

In review, at this point in the focusing procedure, the shape of the person's immediate experiencing has been "met," or "found," or "felt," or "allowed to show itself" (viz. the Second Movement). In the Third Movement, the person now has a single felt sense that encompasses the whole all-about-ness of something, and has now "gone deeper" into this large, vague, felt sense to contact the crux of the felt sense. It is important to notice that the individual has communicated directly with his or her experiencing without, as yet, recourse to any particular words or labels.

The Fourth Movement is called labeling the felt sense. Here the person allows words or images to flow out of the felt sense, thereby letting the felt sense identify or label itself. As it has been true from the beginning of the focusing procedure, it is crucial to avoid forcing words onto the feeling by applying intellectual hypotheses about what it is. Instead the person allows words to come and feels whether the felt sense and the label match. Oftentimes, the person finds that the words may flow out of the felt sense simultaneously with "feeling the crux" (the Third Movement). The labels that come out of the felt sense could be words, images, thoughts, music, or any type of "symbol" that serves to label the crux of the felt sense for the individual.

The Fifth Movement is called checking back with the feeling or "resonating." At this stage, the person takes the "label" that has come from the felt sense, and now "matches" it against the feeling. To do this matching, the person must continue to strongly experience the felt sense. If the confirming sensation does not come --that is, a bodily-sensed awareness of "yes, that's it," or "that's not quite it"-- then the person must allow more accurate words to come from the feeling. However, the judgement of whether the words, images or labels are "accurate" must be made "through-the-body." If the label is accurate, the person will immediately sense a confirming sensation such as an easing in tension, or a shift in bodily-felt well-being. If the label is inaccurate, the labeling will have little or no bodily-felt effect, or may even incur discomfort. If the labeling words are somewhat accurate, the person will sense this bodily, and can then allow other words to flow from the felt sense, which may more correctly match the felt sense. Gendlin (1981) states that sometimes the guiding feeling disappears, leaving the person with only the words. When this happens, it is necessary for the person to let the feeling come as it now is (perhaps slightly changed) before he or she can check the label against the feeling.

The Sixth Movement is called another round of focusing. At this point, the person has grasped the felt sensing and found labels which "carry forward" the meaning of the felt sensing. However, now that the person has "lived with it"

for a while, it is time to go on and get the felt sense of "that which" is under whatever body-message has just been received. In short, it is time to go back through the cycle of focusing movements once again.

In review, we can distinguish between the deliberate and the non-deliberate aspects of the focusing process (Gendlin, 1969a; Gendlin and Olsen, 1970). Trying to maintain the special "set" of focusing constitutes the deliberate part of the procedure. This is the act of deliberately forcing oneself to stay quiet and relaxed and then carefully attending "inwards" to find the felt sense. However, within this specific deliberate set, one is allowing "whatever comes" to arise from the felt sense. This requires a distinctly non-deliberate act of patiently waiting for words and images to come from the felt sense. Meanwhile, one deliberately refrains from forcing these words to come, waiting for them to flow naturally from the concrete felt sense of the problem.

For Gendlin, the focusing procedure described above is certainly not all that experiential psychotherapy is about. The focusing procedure is intended as a practical tool or guide that can be employed usefully in therapy. But "focusing is part of a wider philosophy," which centers around the vital importance of "experiencing" as the basis for human living (Gendlin, 1981, p. 165). Gendlin specifically developed this particular focusing procedure as

a means of facilitating the fundamental process of "experiencing," which he identifies as essential to effective psychotherapy. This is the basis for his assertion that focusing can be taught and used in the context of any therapy (Gendlin, 1969a, p. 4; 1974b). More importantly, he argues that the theories of any "school" of therapy can be usefully employed as long as these concepts are anchored in the experiential felt sensing of the individual client, and serve to explicate his or her immediate experiencing (see Section 9). This is what he calls "experientializing a method." For example, Gendlin has shown how psychoanalytic free association, Jungian active imagery, Rational Emotive Therapy, Gestalt role-playing, client-centered responding, operant situation-restructuring, and systematic desensitization can all involve experiential focusing (Gendlin, 1969a; 1970; 1974b). The following section will examine this central issue in more detail, discussing the proper relationship between theoretical concepts and "experiencing" in the practice of psychotherapy.

8. The Role of Knowledge in Practice.

In several of his writings, Gendlin has dealt with the issue of using clinical theories and concepts in the therapeutic process. He has specifically addressed this central issue in a recent article entitled, "The Role of Knowledge in Practice" (Gendlin, 1974). This article presents a fine practical description of how theoretical concepts can be used helpfully and harmfully in the practice of psychotherapy. It is addressed to an audience that is already sympathetic to client-centered and experiential psychotherapy, and communicates Gendlin's position on the use of conceptual knowledge in a very illuminating fashion. However, before outlining Gendlin's basic position with regard to the role of knowledge in practice, it would be enlightening to first define what Gendlin means by "knowledge," and how it is related to the experiencing process.

As Gendlin states, "psychotherapy is a special area in which the articulation of experience constantly occurs. The individual in psychotherapy struggles with many experiences that he has never symbolized before and for which he knows no symbols" (Gendlin, 1962a, p. 77, italics added). There is no question that accurate verbal and conceptual formulations can facilitate the client's efforts to explore and "articulate" the personal meaning that is being felt in

any given moment. Felt experiencing guides the choice of words and concepts that are used to help the client understand the as-yet-not-articulated meaning, which he or she is presently feeling. When words, theories, concepts, or interpretations are used in direct reference to the experiencing process, they can carry it forward by making the meaningful feeling more intense; by clarifying its meaning; and/or by making it more tangible and capable of being dealt with. For it is the distinct bodily-felt quality of experiencing that constitutes our sense of definite knowing. It is this experiential reference that allows us to "know" with certainty that a particular formulation has functioned to more or less adequately express this or that aspect of a felt meaning. Thus a felt meaning serves both to indicate something potentially known, and to indicate accurate and inaccurate conceptualizations of it.

According to Gendlin, practitioners can employ all kinds of disparate clinical theories in therapy provided they change the way that the theory was intended to function. "We do not give up on theory; rather, we restore theory to its proper relationship to actuality" (Gendlin, 1978-1979, p. 66). In short, theories function to formulate moments of experiencing to which they are applied; they allow an aspect of experiencing to be seen which is then seen on its own. Hence there can be many ways of conceptualizing a given moment of experiencing, and many

theoretical concepts can "bring out" aspects of experiencing that are already there to be clarified. However, at no time does any particular theory itself constitute the actual structure of human experiencing. With this perspective in mind, one could say that it is valuable to be educated in a wide variety of clinical theories because "the more ways of articulating human experience one knows the better" (Gendlin, 1978-1979, p. 66).

Thus conceptual knowledge represents an extremely useful means of explicating experiencing if it is used in the proper manner --i.e., in direct reference to experiencing. "Formulations, and concepts and logic have their use precisely in the power to be precise, to make logical differences, and by differences to point at something experiential that is being missed" (Gendlin, 1982, p. 326, italics added). If a given interpretation is closely attuned to the on-going felt experiencing of the client, it can often function to clarify the client's felt meaning.

Conversely, when conceptual knowledge is inappropriately used to label the client's present experience as a fixed static "thing" --and then equates this conceptual formulation with the felt meaning which the client is exploring-- it inhibits the experiencing process. This is the serious danger of diagnosis and interpretation in therapeutic practice. Diagnosis "freezes" the rich and

multiple meaningfulness of experiencing into a static "thing." Similarly, interpretation can seem completely "true" in its logical relation to the client's verbalizations, and still "miss" the crucial felt meaning of what the client is presently living at this moment in therapy. This is one manifestation of the earlier distinction between conceptualization that functions as the explication of experiencing, and conceptualization that does not (see Section 4).

With this introductory discussion of knowledge in mind, we can now examine Gendlin's five pitfalls of using knowledge in the practice of psychotherapy:

1. Turning the client into a concept-- There is a harmful tendency in clinical practice to try to "figure out" what is "wrong" with the client. This problem is particularly acute when it involves making diagnoses. The use of a diagnostic label reduces the practitioner's sensitivity to the unique human qualities and experiencing of the individual client. The danger is that the therapist may deal with the client as a diagnostic concept, treating him or her as a "manic-depressive," or "compulsive neurotic," rather than encountering the client as a unique individual.

2. The biasing effect-- Another problem with diagnostic labeling, or "figuring out" the client's problem, is that it predisposes the practitioner (often in a subtle

and unreccgnized manner) to interpret the responses of the client in set ways. For example, if a client labeled "manic-depressive" excitedly tells his therapist about his recent thrill at the theater, the practitioner might be predisposed to view this action as evidence of "manic behavior" rather than as a personally rewarding experience. The predisposing "biasing effect" also tends to reduce the therapists's attention to the client's immediate experiencing. The therapist tends to focus more on what he already supposedly "knows" about the client, instead of attending closely to the client's experiencing in the here-and-now.

3. Making "logical" assumptions based on concepts-- Yet another danger of applying concepts is that when the concept fits, there is a subsequent tendency to assume additional "facts" about the client that are logically consistent with this concept. For example, if a psychoanalyst has labeled his client's behavior as "oral-retentive," he will "logically" expect to find certain other facts about the early psycho-sexual development of the client.

4. Differential use of diagnostic concepts-- Gendlin believes that, for the most part, psychologists presently do not have differential treatments for differing diagnostic classes. Therefore there is another clinical danger of inferring different ways of treating people based on

diagnostic knowledge.

5. Static concepts interfere with process flow-- Using concepts has the unproductive effect of rigidly fixing what the problem is, or fixing how the person's personality is structured. The aim of therapy is to facilitate change, and therefore the therapist should avoid concepts that serve only to fix a bad structure, or solidify a consistently troublesome motive or attitude. In Gendlin's own words,

when a person is trying to sense exactly what is wrong, he is sensing with his organism... From conceptual knowing of what is wrong, nothing follows... In the experiencing of what is wrong, positive forces are involved..., whereas in the concepts of what is wrong, no change-avenues are open (Gendlin, 1974, p. 277).

At this juncture, we have outlined five ways in which diagnostic labeling and static concepts can be used to the detriment of therapy. Not only can such knowledge instill harmful biases and constrain the therapist's responsiveness to the client, it can also hinder the free flow of the client's own experiencing. There is always a danger that the client will "introject" the process-fixating concepts of the practitioner because of the therapist's authoritative influence and "expert" direction. Clients typically tend to overvalue the observations and interpretations of the therapist, often in contradiction of their own judgment. For example, a client labeled "manic-depressive" may tend to interpret instances of his or her own behavior in accordance with this diagnosis. In other words, the client may

substitute an alternative "bad structure" in deference to the therapist's interpretation and analysis of "what the problem is." Gendlin's position is that therapy should focus on the client's process of experiencing, and thus concentrate on flow and change, instead of formulating static conceptions of what is happening. This crucial point is pursued further in terms of how knowledge can be usefully employed in clinical practice.

In contrast to the five pitfalls, Gendlin presents seven helpful uses of knowledge (see Gendlin, 1974a, pp. 278-289). These seven "key rules" center on one fundamental principle: "The key to a safe and helpful use of any and every kind of knowledge lies in the reference to, and criterion role of, the directly felt sense and its steps" (Gendlin, 1974, p. 280). These are the seven ways that knowledge can be used positively by the practicing therapist:

1. Always anchor concepts in felt experiencing-- At all times, the therapist should endeavor to make knowledge felt. This means that therapy should focus on felt-meaningfulness as "that which" is immediately "known" in awareness (as it is bodily-felt), and which encompasses all the personal meanings, values, perceptions, and past experiences of the individual client in that given moment of living. This rich well-spring of felt-meaningfulness should

be the source of explicating concepts as well as the criterion of their explicative power. For instance, if a hypothesis such as "fear of failure" is suggested to the client, then the therapist must help the client to get in touch with his felt experiencing in order to check the concept against the felt sense itself. This allows both therapist and client to assess whether the concept "fear of failure" has explicated experiencing (e.g., "yes, that really feels right"), or whether it has been "merely" a conceptualization (e.g., "maybe so, but that just doesn't feel quite right"). No concepts or hypotheses about the nature of the experienced problem should be offered without an immediate return to the felt experiencing from which the ideas have come.

2. Always pursue the experiential effects of knowledge-- If the application of a particular concept has led to a bodily-felt change or shift in the experiencing of the client, then the therapeutic work must pursue this change in felt sensing. The danger of successful concepts is that both client and therapist can become overly impressed with the concept, and forget about its immediate felt significance. Instead they elaborate on the concept and pursue its logical implications. However, the value of the concept has been lost when direct contact with the experiential effect is lost.

For example, imagine that the counselor's hypothesis of "maybe it is a fear of failure," is met with an exuberant affirmation by the client. The correctness of this concept is "judged" by the client's satisfying feeling of tension-reduction, which characterizes the "carrying forward" of his or her experiencing in the given moment. But this does not mean that "fear of failure" was like a static thing (i.e., an "unconscious thought"), which had been lying there until it was accurately labeled in words. Rather, it is that, in this given moment, for this individual client, this particular symbolization explicated some aspect of the client's experiencing, and carried forward its implicit meaningfulness. But a different phrasing of words, or perhaps even a different concept, may have also functioned to explicate the person's experiencing in this given moment. Similarly, the same conceptualization of "fear of failure" might no longer function as explication of experiencing several moments later. For this reason, therapy should always be grounded in the experiencing process rather than based on the concepts applied to experiencing. In turn, changes in experiencing should always be followed, rather than the logical implications of the concept itself. In this instance, it is important to stay with the bodily-sensed change in experiencing that resulted from using the concept of "fear of failure" rather than pursue further logical implications of the concept itself. For example, a therapist could easily go astray by

logically assuming that because the client has a "fear of failure," the client must therefore commit self-sabotaging acts.

3. Previously successful concepts should always be overthrown by later experiential effects-- The therapist should not be concerned with how correct or consistently accurate his concepts have been. Thus, no matter how precise a concept might have been --even if it had yielded tremendous gains in experiential felt change-- later contradictions of this concept should be welcomed. In fact, the felt sense, which the concept helped one to find, may often act to change the basis of that assisting concept.

4. A felt sense is multiple-- As we have seen, one of the defining characteristics of a "felt sense" is its complex whole quality. There are many potential aspects of any given felt sense that can be differentiated and specified, but the whole felt sense itself is always "broad," or "round." It is felt as a "mass," or felt as a whole sensing of the moment. As Gendlin says, there are "many, many potential meanings" contained in any given felt sense, and therefore there is never a single "correct" explication of a felt sense. Many specific concepts can be said from a moment's whole feeling of something-- meaning that many possible concepts can be valid and useful in explicating the felt sense in that given moment. Therefore it is inadequate and inexpedient for a therapist to rely

exclusively upon a specific fixed conception of the problem as defining what is occurring in the therapeutic experience. This harmful use of knowledge in clinical practice tends to narrow the process of experiencing to a static event, "freezing" it as this or that psychological experience. But experiencing always contains much more meaning than is held in the words or concepts used to describe it.

5. Sensing into experiencing yields further movement--
By entering into and feeling the whole of a felt sense, one enters into a "moving living process," from which further "steps" of movement can be articulated. Direct felt sensing is constantly moving and changing, and the concepts which refer to it must also change with it. Concepts, by nature, are static, while experiencing is a constantly changing bodily-felt process of felt meaning.

6. Recognize experiencing as a rich texture and flow, and not as the particular conceptual pattern applied to it--
Theories such as "the Oedipus complex," or "masculine protest," or "identity crisis," should never be taken literally as real structures that constitute the experiencing of the individual client. Human life is a rich texture and flow. Any theory or conceptualization refers to only part of the "globally felt texture of living." At times, concepts and theoretical patterns may serve usefully to "carry forward" aspects of this experiencing, but human life is never just one such pattern. In other words, the

rich flowing texture of experiencing is responsive to various patterning concepts, but experiencing itself is never "just" these static structures or fixed patterns. As experiencing changes, one pattern may serve well in one moment and be completely inappropriate a moment later. Thus one must "allow the same experience already having one set of concepts fitting to it, to still be there for other concepts as well" (Gendlin, 1974, p. 288).

7. Translate theories into likely felt dimensions of experiencing-- When the therapist does engage in reasoning and hypothesis-generation based upon a particular theory, he or she should "keep quiet" about his or her thinking, and avoid interrupting the client's experiencing process with subsequent explanations or recommendations. Instead, the therapist should think of how the client is likely to be feeling, based on the assumption that the theoretical premise holds valid in this moment. The therapist should then check to see if the client is indeed experiencing that feeling which is "predicted" by the theory. This is vastly different from intellectually explaining a theory at someone. For example, the therapist may sense that the client's experiencing involves an "inferiority complex." The practitioner should refrain from defining what an inferiority complex is and explaining what its logical ramifications are for the client. Rather, the therapist would use Adlerian theory in this instance to infer what the client is likely to be feeling and responds to that. Thus,

the practitioner might ask, "do you feel weak and impotent when that happens?"

In summary, Gendlin argues that conceptual knowledge must always be used in reference to direct experiencing. Above all, it is crucial to allow concepts to "come from" a felt sense, in contrast to applying concepts to a felt sense. Practitioners must always use concepts with experiencing, and never use just concepts alone, regardless of how effective the concepts seem to be. Moreover, it is the bodily-felt effect of using concepts, which constitutes the criterion for judging the value of any given conceptualization of experiencing. Distinct "steps" or "shifts" in felt experiencing characterize therapeutically effective concepts, while the application of ineffective concepts yields no felt change. Moreover, when a felt shift does occur, it is that bodily-sensed change which must be pursued, not the intellectual implications of the concept which influenced that change. Finally, since concepts are static, they tend to "fix" or "freeze" the flowing texture of experiencing into set "contents." Hence over-reliance on concepts presents a continual threat to the ever-changing, moving life process of experiencing that is so vital to therapeutic growth.

In closing, we can now understand why many insight-oriented therapists fail to ground verbalizations in the felt experiencing process from which these conceptualizations come. They are ignorant of the felt significance of experiencing, and believe they can overcome the emotional problem by pursuing the logical implications of insights, or by intellectually "figuring out" the underlying causes of the problem (for instance, Adler, 1956; Fenichel, 1945; Alexander and French, 1946; Frank and Asher, 1951; Freud, 1905; Mullahy, 1952). On the other hand, catharsis-oriented therapists fail to distinguish between felt sensing and emotion (Scheff, 1979; Nichols, 1974; Nichols and Zax, 1977). Therefore they do not understand that emotions are not the same as direct experiencing, nor that "emotions themselves" are "about" some more immediate felt meaning. Hence cathartists endeavor to simply vent the bothersome emotions without attending appropriately to the meaningful experiential ground of these emotions.

9. Experiential Psychotherapy Distinguished From
Client-Centered Therapy.

Historically, experiential psychotherapy developed from Carl Rogers' client-centered therapy. This development will be discussed in detail in Chapter 3. However, for the present purposes of describing experiential psychotherapy, we can use the contrast between the two approaches as a way of further clarifying the defining qualities of the experiential method (see Gendlin, 1974b). Stated in brief, Gendlin's clinical experience with client-centered therapy led him to the recognition of what he calls "the vital essence" of Rogers' therapeutic approach (Gendlin, 1974b, p. 211). As Gendlin gained a better understanding of just what it was that made client-centered therapy so effective, he modified his approach to facilitate this essential quality.

In the following quote, Gendlin acknowledges some of the most important contributions of the client-centered movement and its lasting impact on the field of psychotherapy.

Client-centered therapy... first broke the dominance not only of psychoanalysis, but also of the pseudomedical idea that a therapist practices techniques, and that it is these that get someone well. Rogers (1961) emphasized the therapist as a genuine person, rather than techniques... Other contributions of client-centered therapy too, have been absorbed. To mention a few: research with unashamed tape recording of ongoing therapy is no longer exclusive to client-centered therapy... Similarly, most therapists today accept emphasis on the present, and reject the total focus on the past that characterized psychoanalysis. The emphasis on feeling, and rejection of pure intellectualizing, which client-centered therapy began, is widely shared today. Similarly, the client-centered idea that the therapist's feelings toward the client are not necessarily an unreal "countertransference" is now widespread. Real relating is widely accepted. The face-to-face way of doing

therapy, rather than the infantilizing couch, is used today by all but orthodox psychoanalysis (Gendlin, 1974b, p. 213, *italics added*).

However, despite these many valuable contributions, Gendlin (1974b) asserts that the "essence and crux" of client-centered therapy has not been learned by the field. In fact he admits his own failure to emphasize this quality more often in his writings (Gendlin, 1974b, p. 214). Basically, this "essence" is a very special kind of listening (i.e., what Rogers calls "active listening"). It is not merely reflecting what the client has said. It is responding that stays directly in touch with the client's experiencing. It is a careful listening response that helps the client to stay in touch with and enter into his or her feelings (i.e., felt meanings).

Gendlin (1974b) states that two new additions to this special "Roggerian listening" characterize current client-centered therapy. First of all, client-centered therapists have learned the importance of exact specificity in responding to the client. Inaccurate responses or vague approximations of what the client is feeling are not helpful and tend to interfere with the client's efforts to "hold on to" what he or she is feeling deeply. "Today we don't stand for that, we want to say it exactly as the person feels it, and we don't mind trying three times... We recognize that the client's reaction is a comeback to our inaccuracy" (Gendlin, 1974b, p. 215).

The second "amendment" to client-centered therapy is a new insistence that the client check inside to see if the counselor's response has accurately captured exactly what the client is feeling right now. This inner checking is necessary in order to become exact and stay in contact with what is immediately "there" in the client's experiencing. This overcomes the tendency of both therapist and client to "settle for" merely approximate concepts and thereby forget about what is being experientially felt in the here-and-now.

Gendlin holds that these two new specifications of inner checking and exactitude have made client-centered therapy more "experiential." In fact, this new emphasis on the experiencing process is the basis for what Hart calls "the experiential phase" in the evolution of client-centered therapy (Hart, 1970). Therapists are now more aware of the unique essence of client-centered therapy, which has been its cultivation of listening responses that provide a constant baseline for staying in touch with the client's experiencing. It is this special client-centered response that points directly at the client's felt meaning, which Gendlin now calls "the experiential response" (Gendlin, 1968b, 1974b).

There are a number of additional ways that Gendlin has "reformulated" client-centered therapy into an "experiential" approach. One of these has been to convert the three vital therapist attitudes of client-centered

therapy into experiential terms: Gendlin feels that the real meaning of empathy, congruence, and unconditional positive regard is the therapist's use of his or her own ongoing experiential process (Gendlin, 1970). Thus empathic understanding entails communicating one's sensitivity to the client's felt meaning, referring directly to it, and helping the client himself or herself to focus on it and further unfold its meanings. Congruence refers to consistent responding that authentically flows from out of the therapist's own ongoing felt experiencing. Finally, unconditional positive regard means valuing the client as a person, even though the therapist may dislike the client's behavior or the situation the client is struggling with. This means always responding positively to the feelings of the client regardless of his or her actual behavior or illness.

Another way that Gendlin has "experientialized" client-centered therapy has been to change many of its "don't" rules into "do" rules (Gendlin, 1964b, 1970, 1974b). Gendlin notes that many of the guidelines for client-centered therapy are stated as negative "don't" rules-- such as don't interpret, don't ask questions, don't answer questions, don't interrupt, don't express your feelings, and so on. According to Gendlin's experiential approach, any of these rules can be "violated," provided that the client is really listened to before, after, and continually." Thus the "essence" of the client-centered

response is carefully retained as the baseline for therapy. This essence is a heedful listening response that is closely attuned to the immediate felt experiencing of the client. It helps the client sharpen the intensity of his or her experiencing, and thereby carry forward its felt meaning. However, the listening response is now used more precisely to focus on the client's subjective felt process by fostering constant inward checking of verbal responses with inner feelings. In this way, client-centered responding has "steps" that continually "unfold" or "carry forward" the client's experiencing.

These "steps" refer to a general pattern of significant moments in the therapeutic process that further the experiencing of the client. This pattern can be conceptually distinguished as "steps," but there are no inherent units into which the process can be divided. In the first "step," the client has been accurately heard and responded to. In the second "step," the therapist and client check this verbal response against the client's felt sense. Then the next "step" occurs when some meaningful aspect of the client's felt sense is carried forward. For instance, the client might find his or her experiencing has been enhanced and intensified in awareness, or perhaps some aspect of its implicit meaning has been clarified and "correctly" labeled. Guided by this understanding, client-centered responding actually becomes "experiential responding," and the old "don't" rules of client-centered

therapy are seen in a new light:

Thus client-centered therapy has had to be reformulated. Feelings are really "felt meanings," implicitly complex experiencings of situations, of processes that are stopped, or constricted. Responsivity by a therapist, point by point, moment by moment, to the individuals' concrete, bodily felt meaning "carries forward" the process, i.e., allows present experiencing to move beyond hang-ups.

In retrospect we can now look at the old client-centered rules and understand their underlying reason, which was to engender and maximize this experiential process, staying with it, focusing on it, grappling with it, "carrying it forward" (Gendlin, 1970, p. 546).

By understanding this guiding reason for the "don't" rules of client-centered therapy, Gendlin finds it is permissible, even recommended, that the therapist break the "don't" rules. The experiential therapist understands the way that conceptual knowledge functions in experiencing, and is careful not to use it in the harmful, process-inhibiting manner that treats human experiencing as a collection of static experiences to be accurately labeled. In most cases, breaking the "don't" rules involves increased therapist self-expression. We can clarify this point by exploring some specific examples of transforming "don't" rules into "do" rules.

Client-centered therapy has always warned against "making interpretations." The reason was that it turned the client's attention away from what was happening within himself or herself --his or her concretely-sensed felt

meaning-- and focused instead on "mere" intellectual concepts that are far removed from immediate feeling life. The "fundamental axiom" of client-centered therapy is that the client has the potential to know what is best and right for himself or herself, and can trust his or her own subjective experience as a reliable guide for living. Attending to a therapist's interpretation moves the "center" of focus from the client's inward feelings to an outward intellectual sphere that lacks immediate tangible feeling.

In contrast, Gerdlin asserts that interpretation can be used therapeutically as long as it is done "experientially"--that is, by using it in direct reference to immediate feeling. Thus, for example, a male client may sense a heavy round feeling inside him as he speaks about his early family life. The experiential therapist recognizes that this feeling constitutes the way the client's childhood experiences are being presently lived. Thus the therapist can apply Freud's Oedipal theory in this situation by inferring what sort of feelings the client should be experiencing in this moment based on that theory. The therapist does not engage in an intellectual explanation of the Oedipal interpretation. Instead, having inferred what the feeling response should be, the therapist can inquire about that. For instance, if the therapist recognizes a theme of competition with the father in the client's descriptions of his family, he or she might respond, "You must be feeling jealous and angry towards your father right

now..."

Another traditional "don't" rule for the client-centered therapist has been "don't interrupt." Therapists were advised to refrain from mentioning their confusion about something the client said rather than interrupt the client. This rule was intended to keep attention focused on clarifying what the client was feeling, which was deemed far more important than pursuing the therapist's questions about it. On the contrary, Gendlin asserts that it is healthy for the therapist to express his or her puzzlement on such occasions because it actually helps the client clarify these feelings for himself or herself. Furthermore, the client benefits from the experience of having the therapist closely following and prizing his or her every step. Indeed, this is an expression of unconditional positive regard precisely because the therapist accepts what the client says as worth responding to.

As a final example of a "don't" rule, client-centered therapy has traditionally instructed the therapist against expressing his or her opinions and feelings. The aim here was to avoid burdening the client with the therapist's feelings and to maintain "centering" on the client. However, the client's experiencing process cannot be "carried forward" by responses that do not come from a genuine other person. Historically, Rogers himself

increasingly valued the importance of such "congruence" on the part of the therapist. The client needs "an open and self-expressive therapist, a visible and real person who can be lived with" (Gendlin, 1974b, p. 224). If the therapist is not honest with his or her reactions, then he or she is not genuinely "there" for the client to interact with. With an actively self-expressive therapist, the client does not have to imagine what is going on inside the other person. Moreover, the self-expressive therapist provides an on-going "model" of a person who listens inside to his or her feelings, and uses these feelings as a reliable and trustworthy guide for responding. Of course, in drawing upon his or her own experiencing, the therapist must be careful not to intrude on the interactional "space" that the client needs to allow his or her own experiential felt sense to form. As long as this caution is exercised, Gendlin feels it is healthy for the therapist to speak honestly of his or her feelings because it allows the therapist to be more genuine in the therapeutic relationship.

Perhaps the best way to communicate the difference between experiential and client-centered therapy is to present an actual case example. In the following therapy excerpt, the experiential counselor will violate the "don't" rules of client-centered therapy in order to "stay with" the immediately sensed feelings of the client:

CLIENT: I've been doing nothing but taking care of Karen since she's back from the hospital. I haven't been with me at all. And when I do get time now, I just want to run out and do another chore.

LISTENER: You haven't been able to be with yourself for so long, and even when you can now, you don't.

CLIENT: She needs this and she needs that and no matter what I do for her it isn't enough. All her family are like that. It makes me angry. Her father was like that, too, when he was sick, which went on for years. They're always negative and grumpy and down on each other.

LISTENER: It makes you angry the way she is, the way they are.

CLIENT: Yes. I'm angry. Damn right. It's a poor climate. Living in a poor climate. Always gray. Always down on something. The other day, when I--

LISTENER (interrupts): Wait. Be a minute with your angry feeling. Just feel it for a minute. See what more is in it. Don't think anything...

[excerpt taken from Gendlin, 1981, pp. 123-124].

In the above excerpt, one can see the experiential therapist is relying heavily upon client-centered listening and "reflection of feelings." Like a Rogerian, he first listens carefully for the "feeling edge," looking for the essential feelings being expressed in the message. He then reflects this felt meaning back to the speaker. However, towards the end of the segment, the listener senses an opportune moment to focus more directly on the client's immediate felt meaning. Notice how the listener actually interrupts the speaker and offers a clearly "directive"

suggestion to hold onto the feeling and see "what more is in it."

In summary, Gendlin distinguishes his brand of "experiential psychotherapy" from client-centered therapy in terms of the manner in which he uses client-centered responding. He actively focuses on the feeling process of the patient at all times, even though this may involve violating the non-directive "don't" rules of traditional client-centered therapy. Frequently this necessitates therapist self-expression, and, in contrast to client-centered therapy, Gendlin strongly urges honest direct interaction that draws upon the therapist's own experiencing process. For Gendlin, client-centered responding is ineffective and wasteful to the degree that the "reflection of feelings" fails to focus on the client's immediate felt meanings or lacks "exact specificity" in articulating these feelings. Finally, Gendlin's experiential psychotherapy is distinguished from client-centered therapy by the regular use of the "focusing" procedure (described in Section 7). This focusing procedure involves guided instructions and deliberate "directive" efforts on the part of the therapist, which is against the client-centered philosophy of non-intervention.

CHAPTER III -

THE EMERGENCE OF EXPERIENTIAL PSYCHOTHERAPY--

ITS HISTORICAL EVOLUTION, THEORETICAL DEVELOPMENT,

AND SUPPORTING RESEARCH.

10. Introduction-- The Five Periods of Evolution.

Gendlin states that "client-centered therapy has helped give birth to experiential psychotherapy" (Gendlin, 1970, p. 544). In this third chapter, we will explore the significance of this remark in terms of two primary issues. First of all, we need to clarify Gendlin's place within the broader historical context of Carl Rogers' client-centered theory and experimental research. Secondly, we need to establish the practical, theoretical, and philosophical grounds for Gendlin's eventual divergence from the client-centered orientation.

The first step toward achieving these goals is to examine the historical development of the client-centered movement. Several helpful histories are available for this purpose: notably, Kirschenbaum's (1979) biography On Becoming Carl Rogers; Hart's (1970) brief history of "The Development of Client-Centered Therapy"; Shlien and Zimring's (1966/1970) brief history of "Research Directives and Methods in Client-Centered Therapy"; and Gendlin and Tomlinson's (1967) general description of the development of "The Process Conception and its Measurement." The information and frameworks provided in these four sources can be synthesized into a useful picture of the history of the client-centered movement.

Basically, the client-centered approach has evolved through five distinguishable periods or stages, which are suggested in outline below:

Period I - Nondirective Therapy (1940-1948): Emphasis on facilitating positive change through nondirective TECHNIQUES; focus on client.

Period II - Early Client-Centered Therapy (1948-1951): Emphasis on facilitating positive change through ATTITUDES; focus on therapist.

Period III - Mature Client-Centered Therapy (1951-1957): Emphasis on facilitating positive change through the RELATIONSHIP; focus on both therapist and client.

Period IV - The Process Conception (1957-1962): Emphasis on facilitating Rogers' conception of the therapeutic PROCESS; focus on the client in therapy.

Period V - Experiential Psychotherapy (1962-present): Emphasis on facilitating Gendlin's notion of the therapeutic EXPERIENCING PROCESS; focus on enhancing and training client experiential focusing skills in therapy.

The first three historical stages will be briefly described, and will merely outline the general historical context of client-centered therapy (see Section 11). Gendlin emerges during the fourth stage of development. His ideas and research in this time period were intimately tied to the broader movement of client-centered theory and research (see Sections 12-15). The fifth stage marks Gendlin's departure from mainstream client-centered therapy and pursuit of his own philosophical and scientific interests (see Sections 16 and 17). Thus, a detailed examination of the fourth and fifth periods will elucidate the influence of the client-centered approach on Gendlin's work, his role in implementing client-centered therapy research, and the reasons for his eventual departure from

the client-centered orientation.

11. The Early Evolution of Client-Centered Therapy:

Periods I, II, III (1940-1957).

Kirschenbaum (1979) probably offers the most useful starting point for reviewing the evolution of client-centered therapy. He argues that all of Carl Rogers' work has been based on a single "fundamental axiom" (Kirschenbaum, 1979, pp. 75-76). Carl Rogers gradually came to believe in this central assumption, which is now called "the actualizing tendency," during his early years at the Child Guidance Clinic in Rochester (1923-1939):

Most children (people), if given a reasonably normal environment which meets their own emotional, intellectual, and social needs, have within themselves sufficient drive toward health to respond and make a comfortable adjustment to life [Kirschenbaum, 1979, p. 75, quoting Rogers (1939)].

This guiding assumption of an individual drive within every biological organism toward growth, health, and adjustment determined that Rogerian therapy would become a systematic effort to create an environment which facilitated this inherent capacity. Basically, to create an environment that supports growth is to allow the person to be healthy.

Therefore the history of the client-centered approach can be seen as the story of gradually discovering, refining, and researching the precise factors that facilitate the inherent organismic drive toward health, and then implementing these particular therapeutic behaviors and attitudinal conditions. In the following history, we will find that the focus of client-centered therapy gradually evolved from an initial concentration on nondirective techniques; to the key attitudes of the therapist; to the therapeutic relationship itself; to the subjective process of experience and change in therapy.

Period I - Nondirective Therapy (1940-1948).

The first stage of development can be called the period of nondirective therapy. During this period, there was a strong emphasis on nondirective techniques and a sharp focus on the client. The therapist's participation was carefully restricted to avoiding intervention, and helping to release the assumed growth potential in each client. Thus, aside from creating an atmosphere of permissiveness, and refraining from directive intervention of any kind, the therapist was limited to the application of two primary techniques: "reflection of feelings" and "simple acceptance." At this time, reflection of feelings basically consisted of ("mere") therapist re-statements of the semantic meaning of client expressions. The purpose of this technique was to help the client clarify his or her

perceptions and feelings. Simple acceptance was the technique of giving brief affirmations in response to client expressions. For example, the therapist might say, "I see," or "mm-hmm," to indicate his or her careful attentiveness to the client's communications. For the most part, however, the non-directive therapist was distinctively passive in therapy.

Even during this formative period, there was a prominent concern with scientific analysis and validation that would characterize the client-centered movement throughout its history. As noted by Shlien and Zimring (1970), research in this period made several important contributions: the first systematic use of electrical recordings of actual therapy cases; the definition of therapy-descriptive concepts; the development of objective measurements of these concepts; and the application of these measures to interview material. At this time, most of the research relied upon content analyses of client and counselor responses using classification systems for identifying and counting types of in-therapy behavior.

Period II - Early Client-Centered Therapy (1948-1951).

The second stage of evolution can be called the period of early client-centered therapy. In the late 1940's, influenced by his own clinical experiences, Carl Rogers began to focus more attention on the therapist's feelings

and the key importance of the attitudinal conditions provided by the therapist. With the eventual incorporation of the concept of congruence in the years 1949-1951, Rogers proposed that the really crucial therapeutic factors were the attitudes of acceptance (later renamed unconditional positive regard), empathic understanding, and congruence. It was this shift in emphasis from the techniques of nondirection to the special growth-promoting attitudes of the therapist, which distinguishes the period of early client-centered therapy.

During this time, Rogers was also developing a theory of personality and personality change, which was "basically phenomenological in character, and relies heavily upon the concept of the self as an explanatory construct" (Rogers, 1951, p. 532, italics added). In his theory, Rogers stressed the importance of congruence between an individual's self-concept and his personal experiences and perceptions. Rogers and Dymond's classic book, Psychotherapy and Personality Change (1954), is a basic summary of the research conducted during this period. Much of this research concentrated on Rogers' notion of congruence, using category systems applied to recorded verbatim interviews. There was also an important new emphasis on relating this information to the actual outcome of therapy.

Of special note was the pioneering work on the Q-sort method (Butler and Haigh, 1954), which offered an effective method of quantitatively measuring individual self-concept, changes in self-concept, and degrees of congruence between self-concept and experiences. The Q-sort typically consists of 75 to 100 self-descriptive statements printed on cards. The client then "sorts" these cards into piles ranging from "very characteristic of me" to "not at all characteristic of me." Based on the client's distribution of the cards, the researcher can obtain a concrete picture of the client's self-concept. Moreover, by administering several Q-sorts, the researcher can obtain measurable profiles of the client's view of himself or herself (the self-concept), the client's view of how he or she would like to be (the ideal self), and even the client's perception of what "the average person" is like. By comparing the discrepancy between the placement of the self-descriptive statements in these Q-sorts, the researcher can measure the degree of "congruence" between the client's self-concept and how he or she would like to be. Furthermore, by administering the Q-sorts at various times during the course of treatment, the researcher can use the Q-sort as a measure of change in the client's self-concept and ideal self-concept. The general research hypothesis predicted increasing congruence between the client's self-concept and ideal self, and increasing congruence between self-concept and experiences, during the course of treatment. Thus, the Q-sort provided a useful

measure of personality change as a result of therapy. For this reason, the remarkable methodology of the Q-sort would continue to play a large role in research throughout the history of client-centered therapy.

Period III - Mature Client-Centered Therapy (1951-1957).

The third stage in the evolution of the client-centered approach can be called the period of mature client-centered therapy. This period is chiefly characterized by a new emphasis on the therapeutic relationship. In short, the therapeutic attitudes of congruence, unconditional positive regard, and empathic understanding must be lived and experienced by both client and therapist in order for positive change to occur. Moreover, there is a clear realization in this period that effective "reflection of feelings" concentrates on the feelings and emotions in client verbalizations, rather than the mere semantic content.

The essence of this period is captured in Rogers' classic paper, "The Necessary and Sufficient Conditions of Therapeutic Personality Change" (Rogers, 1957). Here Rogers clearly recognized the necessity of the therapist's active role in setting the conditions of therapy. He also realized it is necessary that the client is presently suffering and perceives the establishment of these conditions for growth. Thus Rogers proposed six essential conditions for

therapeutic change. First of all, (1) there must be some type of relationship between therapist and client, and secondly, (2) the client must be in a state of psychological discomfort. Then it is necessary that the therapist provide the three crucial attitudinal conditions. The therapist must be (3) congruent and genuine in the relationship, (4) feel unconditional positive regard for the client, and (5) experience an empathic understanding of the client's internal frame of reference. Lastly, (6) the client must recognize that these conditions have been achieved. The research in this period focused on relating these six conditions to successful outcome in therapy. There was also continuing refinement of the Q-sort method as a way of measuring congruence and personality change as formulated in Rogers' self-concept theory.

12. The Process Conception in Client-centered Work.

Period IV (1957-1962).

By the mid-1950's, client-centered therapy had firmly established itself as a major approach in counseling and clinical psychology. It had attained a large following of practitioners and possessed a solid ever-expanding research base. An indication of the magnitude of the client-centered

movement is provided by Cartwright's "Annotated Bibliography" of 1957, which reported 110 theoretical and research studies in the client-centered orientation. In fact, Kirschenbaum (1979, p. 206) has shown that the actual number of studies for the period 1943-1957 is close to 200!

In short, client-centered therapy was enjoying a "booming" period of optimistic progress in theory, practice, and research. Then, during the late 1950's, two major developments would have a dramatic impact on the growing client-centered movement. First of all, it was well-known that client-centered therapy had been predominantly limited to the community and student clientele of university outpatient settings. Therefore there was a desire to "prove" the broader effectiveness of client-centered therapy by extending it to other populations, specifically to "normals" and schizophrenics. As we will see, working with these types of patients required some drastic changes in the conduct of client-centered therapy: above all, the therapist needed to take a much more active role in therapy.

Secondly, in 1955 Gendlin had introduced an exciting new conception of the process of therapeutic change, which was called "experiencing" (Gendlin and Zimring, 1955). Carl Rogers was greatly impressed by Gendlin's theory of experiencing. In 1957, he spent many long hours listening to tape-recordings of therapy sessions in order to get a fresh view of the essential nature of the therapy

experience. In this unique program of naturalistic observation, Rogers endeavored to set aside all his preconceptions about therapy in order to newly grasp the central processes of the therapeutic experience. In fact, Gendlin and Tomlinson (1967, p. 120) claim that Rogers undertook this project on the basis of Gendlin's (1955, 1957) theory of experiencing. Based on his new observations, Rogers derived seven different co-varying "strands" of client behavior that were indicative of positive "movement" in therapy (listed in Section 14). This "new process conception" was described in Rogers' address to the American Psychological Association in 1957, and later published in a landmark paper in 1958.

The significance of this paper lies not only in the specific process conception it outlined, but also in the overall emphasis of the argument on a pervasive process of personality change embracing all significant aspects of the client's changing inner life and its effect on his personal relationships and life situation... In his "Process" paper, Rogers laid the groundwork for the broadest and potentially most productive phenomenological conception, that of experiencing (Hart, 1970, p. 10).

Rogers gradually developed the seven in-therapy behavior patterns outlined in the "Process Paper" into a full-fledged process theory. In addition, he closely related these behaviors to his theory of the necessary and sufficient conditions for therapeutic change (Rogers, 1957; see discussion in Section 11). In brief, assuming that the therapist attitudinal conditions of empathic understanding,

congruence, and unconditional positive regard have been secured in the relationship, the research emphasis now turned to explaining and measuring the variables of flow and movement within the client in the ongoing therapy process. It was the emergence of this new emphasis on "process" that marked the shift to the fourth stage in the evolution of client-centered therapy. Historically, Gendlin's early theory of experiencing played an important role in the development of this process conception (Gendlin and Zimring, 1955). In fact, Hart (1970, p. 10) claims that the process concept of experiencing originated with Gendlin and Zimring (1955). For these reasons, it is crucial to examine the theoretical importance of the "new process conception," and explore its historical development in the client-centered movement.

Actually, the significance of the process conception was first addressed in Chapter 1 of this dissertation. As Gendlin (1962a) has shown, it requires a fundamental re-thinking in psychology in order to accurately conceive of human experiencing as a living, moving process. In particular, it necessitates a complete shift in the way psychologists typically use concepts and operationalize variables. A process conception, which views human life as a stream of ever-changing experiencing, is drastically different from viewing personality and behavior as a structured accumulation of "contents" from past experiences.

As noted in Section 3 on "implicit meaning," content conceptions view human experience as built-up of static elements or ingredients. In effect, each significant life event constitutes another ingredient in the total accumulation that constitutes the individual's experience at this point in time. Viewed in this way, personality change must become a matter of adding new contents, or deleting old contents, or reorganizing present contents in some new way. Thus "contents" can be variously conceived of as "traits," "S-R bonds," "experiences," "archetypes," "instincts," "the self-concept," or any variety of such notions. However, in each instance, for whichever theoretical approach, experience is basically formulated as discrete units. Moreover, the problems of this content approach are often compounded by the "repression paradigm," which posits some sort of "unconscious mind" as the vast reservoir of these accumulated units of experience. "Humans should not be conceived as containers with thing-like entities within" (Gendlin, 1966b, p. 84).

In contrast, the process conception of experiencing is pre-conceptual. Experiencing is never merely this or that "experience," or the push of an "instinctive drive." It is an on-going immediate flow that we can recognise through our constant "felt sense" of "all that" which is being experienced in this moment. Some aspects of experiencing may be conceptualized as this or that "experience," but experiencing itself is always much more than "just" that

conception. .

For example, in 1951 Rogers had used a content conception in his theoretical definition of "the self." The self was conceived of as an enduring structure, which could assimilate ("add on") or reject discrete units of experience with regards to that structure:

The structure of the self is ... an organized, fluid, but consistent conceptual pattern of perceptions of characteristics and relationships of the "I" or the "me," together with values attached to these concepts (Rogers, 1951, p. 498, italics added).

Psychological adjustment exists when the concept of the self is such that all the sensory and visceral experiences of the organism are, or may be, assimilated on a symbolic level into a consistent relationship with the concept of self (Rogers, 1951, p. 513).

In the above quote, the word "fluid" provides an early clue of the direction in which Rogers' ideas were moving. Indeed, by 1959, Rogers had abandoned the notion of an enduring structural self and had embraced a new process conception of the self:

The self is primarily a reflexive awareness of the process of experiencing... It is not a structure to be defended, but a rich and changing awareness of internal experiencing (Rogers, 1959a).

Having now established the significance of the process conception for psychological theory, we can turn to the historical development of the process conception. Gendlin states,

The reformulation of client-centered concepts in terms of the experiencing process occurred over the years 1955-1958. It was deeply grounded in Rogers' earlier work, and in turn influenced his later work (Gendlin, et al., 1968, p. 223, *italics added*).

Specifically, Gendlin and Tomlinson (1967) cite three main sources of the process conception in Rogers' theory. First of all, Rogers (1957) had questioned the necessity of diagnosis, suggesting that diagnosis may decrease counselor effectiveness by committing him to a prematurely fixed impression of the client. Diagnostic concepts thus hindered the client-centered aim of understanding the unique life-world of the client in an open, nonjudgmental fashion. The client-centered therapist's purpose is to concentrate on the client's concretely-sensed feelings in the here-and-now, and to provide responses that help articulate the personal meanings in these feelings as they are experienced.

Secondly, Rogers held that any organism will inherently "move toward" life-enhancing manners of adjustment when provided with a healthy climate that encourages openness to organismic experiencing (i.e., a climate characterized by the attitudinal conditions of unconditional positive regard, empathic understanding, and congruence-- see Rogers, 1957, 1977). The third source of the process conception was Rogers' emphasis on "trusting one's own experiencing," which was a call to use one's organismic valuing process (i.e., one's "ongoing psychophysiological flow") as a guide for behavior. In effect, this meant actively using immediate

ongoing experiencing to develop new ways of expressing and organizing experience. This was contrasted against trying to "fit" experience to an existing static structure of concepts and values. For example, rather than translating her feelings of rejection by a suitor into further confirmatory evidence of her "loser" status, Sue might use her immediate experiencing of rejection to reveal insights into the actual qualities of her communication style.

In his careful analyses of therapeutic movement, Rogers (1959a) was perplexed by the apparent impossibility of directly checking "congruence" between a client's conceptualizations and the contents of his experiences.

Gendlin and Zimring (1955) took the next step. They began with the observation that during psychotherapy feelings and personal meanings --until then supposedly "in" experience but not "in" incongruent awareness-- not only emerge but change as the client attends to them, expresses them, and is responded to (Gendlin and Tomlinson, 1967, p. 113).

In this way, Gendlin and Zimring (1955) first proposed a theoretical formulation of personality as an on-going process of experiencing. This view contrasted with existing content conceptions of human personality as a structure or static collection of "experiences". They introduced the term "direct referent" to describe the immediate, bodily-sensed feelings of client experiencing. In the 1955 paper, they concluded that immediacy of experiencing is inherent in the therapy situation, and depicted therapy as

involving both client and counselor efforts to employ words pointing to the client's immediate experiencing. In this work, Gendlin and Zimring (1955) also suggested methods for measuring this new process conception. Some of these ideas were later implemented in a therapy effectiveness study of "immediacy of experiencing" by Gendlin, Jenney, and Shlien (1956, 1960).

In the years following 1955, Gendlin (1957, 1958) continued to further develop this theoretical formulation of the experiencing process. Moreover, it is clear that Gendlin's early formulations of the notion of "experiencing" significantly influenced Rogers' thinking in this period. Rogers himself (1980, p. 141) states that "the concept of 'experiencing' as formulated by Gendlin (1962)... has enriched my thinking in various ways." Others concur that Gendlin's experiencing notion had a significant impact on Rogers' thinking in the late 1950's (Hart, 1970, p. 10; Shlien and Zimring, 1970, p. 45; Kirschenbaum, 1979, p. 279; Rogers, et al., 1967, p. xviii). However, it is important to remember that Gendlin's work in this period was largely devoted to the collaborative efforts to further theory and research in client-centered therapy. It was not until 1962, that Gendlin announced his theoretical break with Rogers and the client-centered orientation (Gendlin, 1962a), and began the major pursuit of his own philosophical and scientific interests (see Sections 16 and 17).

In conclusion, the new process conception heralded a new direction for theory and research in the client-centered orientation. In particular, it was now vitally important to demonstrate that the process conception could be scientifically measured and observed. Obviously, to implement and incorporate this new conception of the experiencing process required the use of appropriate process variables rather than traditional content variables. Furthermore, it demanded effective and reliable means of operationally measuring these new process variables. In the following sections, we will closely examine efforts by Gendlin and his colleagues to achieve these goals. Section 13 describes some early experimental studies of process variables, while Sections 14 and 15 describe the bulk of the client-centered research, which was centered on the methodology of the "Process Scale."

13. Early Experimental Studies of Process Variables, (1955-1961).

In this section we turn to an examination of some of the initial efforts to formulate quantifiable variables from the new process conception of experiencing. For organizational purposes, I have separated these early

experimental studies from the subsequent series of related studies based specifically on "the Process Scale" (see Section 14). The discussion of each respective research approach will be designated by a heading listing the type of process measure used.

1. Counselor Ratings of Process-- Gendlin, Jenney, and Shlien (1956, 1960).

An early study by Gendlin, Jenney and Shlien (1956, 1960) represented a pioneering effort to implement a quantitative measure of process in therapy. In this study, they were specifically interested in the association between counselors' ratings of the outcome of therapy, and counselors' observations of the quality of experiential process in therapy. Sixteen counselors agreed to evaluate the "immediacy of experiencing" of their clients during the 7th and final interviews of time-limited psychotherapy (duration not reported). The counselors also rated the outcome of therapy on another scale ranging from negative to positive effects. Thus the sole measure of therapy "effectiveness" in this study was a single counselor rating of outcome. The authors state that the counselors made these ratings "without any knowledge... of the diagnostic test results on other evaluative measures" (Gendlin, Jenney and Shlien, 1960, p. 212). However, the authors neglected to identify what these "other measures" were, and failed to report the mean scores of these measures. Hence, the

research design consisted of correlating a few scale ratings of process with a single rating of outcome. No control group was used for comparison with the 39 clients who agreed to participate in the study.

Each of the six process items in this study was rated on a 9-point scale. Three of the items pertained to "using the therapeutic relationship for immediate significant experiencing," while the other three items pertained to "merely talking about the relationship as a topic of discussion." As predicted, Gendlin, Jenney, and Shlien (1960) found positive therapy outcome was significantly correlated with using the therapeutic relationship for immediate experiencing (as measured by the following three scales):

1. To what extent does the client find that his relationship with you is an important instance of the difficulties he has generally? [scale ranges from "not at all" to "very significantly"].

2. How important to the client is the relationship as a source of new experience?

3. To what extent does the client express his feelings, and to what extent does he rather talk about them? This scale differentiates direct expression from report about one's feelings, regardless of whether the feeling is past or present. [scale ranges from "talks about feelings past or present" to "expresses feelings of the moment"].

This third scale item, in particular, illustrates how counselors could rate the client's "immediacy of experiencing" as a process. One extreme of this scale is

expression of feelings in the here-and-now, and the other extreme is mere "reporting" about one's feelings, past or present. Direct expression would be evidenced in client statements like, "I feel very depressed right now," or "I'm furious at you." In contrast, statements like "often I feel depressed," or "generally I don't get angry," show no indication of immediate feeling in expression or intonation. The important point is that the immediacy of the client's experiencing can be measured without regard to the conceptual content of that experiencing. Thus the client could score highly on expression of feelings whether those feelings involve anger, love, resentment, guilt or anxiety, and whether the feelings are rooted deep in the past or are of recent origin.

On the other hand, Gendlin, Jenney and Shlien (1960) found that counselor ratings on three scale items that pertained to "merely talking about the relationship as a topic of discussion" were uncorrelated with therapeutic outcome. It should be noted that two of these items (items 4 and 6 below) were adopted from an earlier study by Seeman (1954), which also found no correlation between these items and therapy outcome.

4. Does therapy, for this client, focus chiefly on his problem, or does it focus chiefly on his relationship with you? This scale separates relationship from problems, regardless of the qualities of either. [scale ranges from "focus on his problems" to "focus on relationship with you"].

5. To what extent does the client talk about your general characteristics such as age, sex, looks, beliefs, background, school of therapy, etc.? [scale ranges from "often" to "rarely"].

6. To what extent do the problems focus in the past (childhood or earlier years)?

Based on this study, Gendlin, Jenney, and Shlien (1960) concluded that the successful client is characterized by (1) immediacy in expression of feelings (as opposed to merely "talking about" feelings), and (2) active use of the relationship for immediate experiencing of feelings. However, this conclusion must be tempered by a more careful examination of the results of the experiment. To begin with, there is a problem with the operational definition of "successful outcome" of therapy. There was only a single measure of positive outcome reported --counselor ratings of outcome-- and the external validity of this measure is questionable. Specifically, it is unknown whether scores on this sole outcome measure are consistent with other psychometric measures, which are more generally accepted as reliable and valid instruments of assessing therapeutic changes in personality and behavior. In fact, in a later discussion of this particular research, Gendlin acknowledges that a battery of outcome measures had been used in this study:

The scales measuring expression of immediate experiencing correlated highly with several success measures, while the scale of past or present content did not (Gendlin, 1962a, p. 248, *italics added*).

This statement raises further questions about this research study. There is no identification of these "other measures," nor any indication of the degree to which these measures did or did not "agree" with counselor ratings of therapeutic outcome. For this reason, we can question the validity of the counselor ratings of outcome as the only measure that was significantly correlated with the scale ratings of experiencing. In other words, it is dubious to reject the information from a whole battery of outcome measures in favor of a single measure, which had yielded statistically significant support for the hypothesis. It could be that the "other measures" constitute a more accurate indication of whether the measure of experiencing level is related to positive outcome.

Moreover, since this is a correlational design, it must be remembered that a significant correlation does not indicate a causal relation between variables. There may be no causal relation between "experiential focusing" and "positive therapeutic outcome" despite the correlation between the rating scale measures of experiencing and counselor ratings of outcome. A strong correlation can result from the correlation of the two variables with a third unknown variable, such as intelligence. Furthermore, since the study lacks any type of comparison or control group, it is unknown if outcome and process ratings would be any different for an equivalent "non-therapy" group. This is an interesting question because the process ratings for

the 7th interview were not significantly correlated with counselors' ratings of outcome. [In fact, this finding conflicts with subsequent Process Scale research, which consistently found that high process ratings from the earliest sessions of therapy can predict subsequent success or failure-- see Sections 14 and 15).

Finally there is a problem with possible biases of the counselors, who rated both the process and outcome variables. The raters may have been given a set about what was desirable as process quality, and this may have effected their ratings of outcome. In contrast, objective measures, such as TAT and MMPI scores, are not based on the counselor's judgment, which is inherently biased by his or her earlier therapeutic experiences with the client. For this reason, the two measures of process level and outcome lack "methodological independence" in this correlational design. Moreover, the measures also lack "theoretical independence" because high levels of experiencing are already presumed to characterize the essential nature of positive therapeutic growth.

In view of the many problems with this research study, there are severe limits on the generalizability of these results to conclusions about effective therapy. At best, Gendlin and his colleagues had demonstrated a useful way of measuring a process variable. Specifically, this study shows that it is possible to measure counselors'

observations of clients' intensity of experiencing, whether or not there is conceptualization into content.

2. Client Q-Sort Measures of Experiencing-- (Gendlin, 1961a; see also Gendlin, 1962a, pp. 249-250) and (Gendlin and Shlien, 1961).

In another early study, Gendlin (1961a) proposed a client Q-sort technique as a method of operationalizing the new process conception. In this study, Gendlin was specifically interested in measuring instances of direct reference to immediate experiencing with only minimal or inadequate conceptualization. Below are several sample items taken from the 32 item Q-sort, which was administered to clients during and after therapy. The complete list of items is printed in Gendlin (1962a, pp. 249-250) and the results are briefly discussed in Gendlin (1961a). Clients were asked to Q-sort statements about their personal experiences in psychotherapy. Each statement describes occasions when the client tries to understand unclear feelings or has strong feelings that are not yet understood.

3. I felt the therapist's presence intensely, although I didn't know what to do about it.

5. It turned out to be exciting not to know just what we were doing.

6. I had a certain shaky feeling because it was up to me how we proceed.

7. Something I thought we couldn't do turned out to be quite possible for us.

21. I felt certain exciting possibilities for me, though I don't know just what they are.

25. I felt a certain thing (which I wish I could change) more intensely than I ever have before, but it hasn't changed yet.

In reviewing the results of this Q-sort study, Gendlin (1961a) made the following conclusion:

Preliminary findings show that success ratings by counselors correlate significantly with client's scores on this Q-sort. The finding is a preliminary indication that clients succeed in therapy if they often experience immediately present feelings which they do not as yet understand (Gendlin, 1961a, p. 244, italics added).

Closer examination of the study severely restricts the experimental validity of these conclusions. Not only was this "preliminary" study never published, but Gendlin does not provide any descriptions of the method or results of this experiment. For example, he reports that the Q-sort measure was also correlated with other measures of outcome: TAT, Rorschach, Self and Ideal Q-sorts, Counselor and Client Ratings of Outcome and Change, and Trait-Feeling Q-sort (see Gendlin, 1962a, p. 250). However, there is no mention of the empiric results of these measures. It is unknown whether the Q-sort correlated only with the counselors' success ratings, and not with the other measures. Furthermore, it is unknown whether the "significance" of the correlation endured beyond the "preliminary" analyses of the

data. In short, this study simply cannot stand up as a sound experiment.

Nonetheless, this does not mean that the study was meaningless and not worth reporting. At the very least, the study showed that this particular Q-sort method was another promising indication that the experiencing process could be effectively measured with quantifiable variables. Specifically, it provided a way to measure "direct reference" to feelings that are not yet conceptualized or understood by the experiencing client. Thus it suggested a possible way to measure instances when the client directs attention "inwardly" to a particular felt datum, such as "I feel it," or "there it is again," or "something doesn't feel right," even though the client does not yet know what "it" is.

In conclusion, this preliminary Q-sort study was valuable in two general ways: first of all, it suggested the Q-sort as another possible way to operationalize the new process conception in client-centered research. Secondly, it offered some preliminary experimental support for Gendlin's assertion that there is a vital phenomenon of "direct reference" occurring in the therapeutic experience (see Section 6). Nevertheless, as we have seen, the credibility of these "preliminary results" is highly questionable. Therefore, based on the weakness of this particular evidence, Gendlin cannot make the conclusion that

higher levels of immediate experiencing lead to success in therapy.

In a second related study, Gendlin and Shlien (1961) developed another client Q-sort measure of experiencing. In this study, clients would Q-sort attitudinal statements on a 5-point scale ranging from "very like myself" to "very unlike myself." Based on Taft's (1953) theory of immediacy, this "Time-Attitude Q-sort" consisted of self-descriptive statements which were positively, negatively, and un-related to immediacy of experiencing. Previously, Shlien (1957) had reasoned that time-limited therapy should maximize immediacy of experiencing because there is "less time to waste" due to the time restrictions. In the present study, Gendlin and Shlien (1961) compared two groups of clients in time-limited therapy, predicting that the attitudinal preference for "living in the here-and-now" would be significantly correlated with positive outcome of therapy. There were two groups of clients in this study: One group of 23 clients did the Time-Attitude Q-sort following completion of time-limited therapy consisting of twenty-two interview sessions. A second group of 22 clients did the Q-sort before and after time-limited therapy consisting of forty interviews. A sampling of the Q-sort items positively related to immediacy of experiencing is listed below:

8. Nothing in life is absolutely final-- endings also lead to beginnings.

9. Every day is a fresh opportunity for me

11. I live in the present.

26. I work hard for as long as a job takes, then relax and forget it.

30. A challenge is stimulating for me.

This is a sampling of the Q-sort items that were negatively related to immediacy of experiencing.

12. I live in the past.

16. I'm often too worried about what may happen to be really absorbed in what is happening right now.

17. I often do nothing at all because there are so many different things I ought to do.

24. I often do things when the doing has no satisfaction, just to be able to look back on them.

35. I am often pushed into things I didn't want to do.

37. To be satisfied with a relationship, I have to feel that the other person is not withholding anything.

There were several interesting findings in this study. On one hand, Gendlin and Shlien (1961) found that pre-therapy scores on the Time-Attitude Q-sort were not correlated with the Time-Attitude scores at the end of therapy, and that pre-therapy Time-Attitude scores were also not correlated with the therapy outcome measures. On the other hand, the post-therapy Time-Attitude scores and Time-Attitude Change scores were significantly correlated

with some of the outcome measures.

There were several outcome measures used in this study. For each client in the 20 session group, four measures of outcome were taken at the end of therapy: Counselor Rating of Outcome, Client Rating of Outcome, TAT score, and Self-Ideal Correlation using the Butler-Haigh Q-sort (see discussion of Q-sort methodology in Section 11). For each client in the 40 session group, measurements were taken during the seventh interview and at the completion of therapy, thus providing three additional outcome measures: Counselor Rating of Change, Client Rating of Change, and Change in Self-Ideal Correlation. Finally, with the exception of the TAT score, all given measures were combined into a Composite score for each client in both groups.

The results showed three significant correlations between the Time-Attitude score and Client Rating of Outcome, Self-Ideal Correlation, and Composite score. For the 40 session group, significant correlations were also found between Time-Attitude Change score and the Counselor Rating of Change, Counselor Rating of Outcome, Change in Self-Ideal Correlation, and the Composite score. It is noteworthy that none of the individual outcome measures were significantly correlated with both the Time-Attitude and Time-Attitude Change scores. Furthermore it is interesting that the TAT was the only "objective" measure independent of direct counselor and client judgments of outcome, and it was

not significantly correlated with either Time-Attitude measure. This suggests the possible biasing influence of a "set," in which clients and counselors were aware of the social desirability of certain ratings and responses. For example, a client who rated himself or herself high in positive change, might be inclined to make sizable changes in his or her Q-sort ratings to be consistent with that self-rating of positive change.

One drawback of this study is the failure of the authors to report the inter-correlations between the outcome measures themselves. For this reason, it is unknown whether there is a consistent picture of agreement among the various measures about what constitutes a "successful outcome" case. If there is inconsistency among the outcome measures, it is possible that the measures are tapping into different phenomena altogether. Or, more fundamentally, there is a question of the validity of the idea of "successful" outcome and its measurement here. Again, it is noteworthy that the single standard "objective" measure used in this study (TAT score) appeared to be inconsistent with the client- and counselor-based measures.

In summary, Gendlin and Shlien (1961) concluded that "high degree of immediacy" (operationally defined as a high score on specified items of the Time-Attitude Q-sort) was significantly correlated with the successful outcome of therapy. Although this Time-Attitude Q-sort measure

indicated that "successful" clients tend to hold certain attitudes about spontaneity and immediacy in felt experiencing, there was no direct process measure of what was really happening in therapy for these individuals. Therefore there is no way to know whether and how these attitudes become manifested in actual in-therapy responding. It is entirely possible that individual Time-Attitude scores could be correlated with therapeutic outcome even though the individual was not truly acting in a spontaneous experiential manner.

There is another theoretical problem here. According to the general theoretical hypothesis, intensive involvement in the felt experiencing process is the ground for therapeutic change. Therefore a person who tends to be more in touch with his or her felt experiencing process should score high on the Time-Attitude Q-sort as a measure of this process. If this is true, then either (1) there should be a strong correlation between the outcome measures and the Q-sort measure of process both early in therapy (i.e., the seventh interview) and late in therapy, or (2) the level of experiential process should increase during the course of treatment (i.e., changes in the Q-sort measure) as a result of training in experiential focusing. It would appear that the results in this study correspond with the latter event because the pre-therapy Q-sort was not significantly correlated with the outcome measures, while the post-therapy Q-sort measure was. At the same time, this finding

conflicts with later client-centered Process Scale research, which consistently found that high ratings of process level in the first sessions of therapy accurately predicted subsequent success or failure in therapy (see Sections 14 and 15). In this study, there was no significant correlation between the early seventh interview scores on the Time-Attitude Q-sort and subsequent outcome.

In conclusion, the shortcomings of this Q-sort research study also limit any conclusions that might be made about the role of experiencing in therapeutic outcome. Although the Time-Attitude Q-sort represented another possible method of measuring "the new process conception," it was perhaps the weakest process measure because it failed to provide any direct measure of actual in-therapy behavior. In contrast to the other Q-sort approach (Gendlin, 1961a), which described actual experiences of "direct reference" in therapy, this Q-sort measured only "mere" attitudes about immediacy of experiencing.

3. Physiological Measures of Experiencing-- (Gendlin and Berlin, 1961; also discussed in Gendlin, et al., 1967, pp. 230-231).

Also during this time period, Gendlin conducted research on physiological correlates of the experiencing process (Gendlin and Berlin, 1961). Similar psychophysiological studies had already been reported by Berlin (1960) and Matarazzo, et al. (1958), which found that different interview conditions have differing autonomic correlates (Gendlin, 1962b). This supported "testimonial" clinical evidence, which had indicated that direct reference to experiencing yields a distinct easing of tension, even when the client is dealing with a personally painful topic (see Section 4). Therefore, since direct reference to experiencing was assumed to be the basis of positive therapeutic change, Gendlin reasoned that organismic tension-reduction should characterize direct reference to experiencing. He predicted that there should be measurable physiological tension-reduction during periods of continuous reference to experiencing.

To test this hypothesis, Gendlin and Berlin (1961) measured galvanic skin responses (GSR) of 17 college students during a tape-recorded instructional sequence of seven "modes" of experiencing. From among the many types of GSR measures that might be indicative of "tension-reduction," Gendlin and Berlin chose to use linearity (defined as the absence of deflections), and increment (defined as the increase in resistance between the beginning and end of each experimental period). The selection of these GSR measures was made on the basis of

previous "pilot observations" even though Gendlin and Berlin acknowledged that there is "no rigorous theoretical basis" for making such a selection (Gendlin and Berlin, 1961, p. 74). The seven experimental periods are listed below. Each period lasted two and a half minutes following the instructions, and they were presented in the following sequence: c2, b2, b3, a2, b1, a1, c1.

a1 - continuous reference to experiencing with disturbing personal content (silence).

a2 - continuous reference to experiencing with undisturbing personal content (silence).

b1 - discontinuous reference to disturbing personal content (silence).

b2 - discontinuous reference to undisturbing personal content (silence).

b3 - continuous attention to an external object --table (silence).

c1 - speaking out loud about undisturbing personal content.

c2 - speaking out loud about disturbing personal content.

An analysis of variance was conducted on the two separate GSR measures, and three major comparisons were made. The first comparison found that there were no significant differences between the type "1" (disturbing content) and type "2" (undisturbing) periods. Gendlin and Berlin concluded that this supported the hypothesis that there are no differences in tension-level due to the "content" of experiential focusing-- i.e., whether the topic

is personally disturbing or not. However, this conclusion is simply not justified. Gendlin and Berlin (1961) made the elementary methodological mistake of assuming that finding no statistically significant difference demonstrated support for the hypothesis that there is no difference between the treatment conditions. In short, you cannot state a hypothesis that predicts no significant differences! That is the same as predicting the null hypothesis.

The second major ANOVA comparison looked for differences between type "a" silences, type "b" silences, and "c" periods of talking. Here they made the obvious conclusion that there are measurable physiological differences between talking and silent states. There is certainly nothing surprising about this finding.

The third analysis made comparisons of the seven individual experimental periods. Using Duncan Range Tests, Gendlin and Berlin (1961, p. 76) found that "23 of the 32" possible differences were "significant in the predicted direction." The results tended to support the hypothesis that self-interrupted or externally focused silences (type "b" periods) differ from silences involving continuous reference (type "a" periods). Mean scores on the increment GSR for the a1 and a2 periods respectively were significantly greater than those for b1, b2, and b3. It is interesting to note that there were no significant differences found on the linearity GSR measure except for

the a1 vs b1 comparison. This inconsistency between the two GSR measures is not discussed by the authors.

Based on this third analysis, Gendlin and Berlin concluded that there is greater tension-reduction during continuous reference to experiencing than during discontinuous reference. However, this conclusion is open to alternative explanations. First of all, this result may be more readily attributed to the disruptiveness of the experimental instructional procedure. It would seem natural that actively interrupting one's own mental processes would induce higher physiological tension than continuous focusing on a topic. Obviously it is more difficult to "think about various things, not just one" (the b2 instructions) than it is to "continue thinking about one feeling as much as possible" (the a1 instructions). This procedural manipulation may be the actual source of the measured tension-reduction.

Above all, the single greatest limitation of this study pertains to the generalizability of the findings. There is a huge discrepancy between the artificial laboratory situation used in this study and an actual psychotherapy session. One could argue that the instructions used in this laboratory setting do not even remotely resemble genuine instances of direct reference to felt experiencing in therapy. The glaring difference is readily apparent by looking at the actual instructions given to the subjects.

The instructions below are intended to represent continuous reference to experiencing with undisturbing content (period a2), and continuous reference with disturbing content (period a1).

a2-- Now, silently to yourself, try to remember as many of your schoolmates in the early grades of school as you can. Try to remember them, and, if you can, their names.

a1-- Please think about some one specific aspect of the problem. As you think about it, try to feel it as specifically as you can. If you find yourself thinking about many different things, please again choose one feeling from among these and continue thinking about one feeling as much as possible.

To some degree, Gendlin and Berlin (1961) acknowledge the crucial problem of trying to generalize laboratory findings to actual therapy situations. But they do so in terms of suggesting that they might use "other instructions" based on the same theory. Finally, they recognize that there are alternative theoretical interpretations for the process they are calling "continuous reference." They suggest, for example, that critics might explain these results as "basking in regressive thoughts," or as "a light, self-induced hypnotic trance." But they do not question the methodological soundness of the basic empirical findings of the study.

In summary, this psychophysiological study suffers from a number of methodological problems, which severely restrict conclusions that might be made about the process of

experiencing in therapy. Like the other early studies we have reviewed, this study is limited by serious methodological flaws. Similarly, the best "conclusion" that can be made from this particular study is that physiological measures may offer another possible way of operationalizing a process variable.

14. Experimental Research Using the Process Scale, [1958-1967].

Thus far, we have noted three general methods which Gendlin and his client-centered colleagues had used to operationally define and measure the new process conception of experiencing. (1) In the first method, Gendlin, Jenney and Shlien (1960) used the "external" judgement of counselors, who evaluated the level of client experiencing in therapy with counselor rating scales. (2) In the second method, Gendlin (1961a) and Gendlin and Shlien (1961) used the "internal" judgement of the clients themselves, who responded to self-rated client Q-sorts measuring immediacy of experiencing. (3) In the third method, Gendlin and Berlin (1961) suggested a physiological measure of experiencing in therapy, using the GSR.

However, the most important and extensive research efforts to implement the new process conception involved a fourth methodological approach: (4) the Process Scale. Clearly it is the Process Scale research that Gendlin most often cites as experimental support for his position on the central importance of experiential focusing in therapy (for example, see Gendlin, 1981, pp. 3-9). By implementing a broad range of interrelated process variables, the "Rogers Process Scale" represented the most cogent means of "getting at" the observable experiential conditions that characterize "effective therapy."

Historically, the basic Process Scale approach was launched in 1957 by Carl Rogers' naturalistic observation of tape-recordings of therapy interviews (discussed in Section 12). As a result of his efforts, Rogers identified seven experiential variables in the therapy process: (1) feelings and personal meanings, (2) manner of experiencing, (3) degree of incongruence, (4) communication of self, (5) the manner in which experience is construed, (6) the relationship to problems, and (7) the manner of relating to others. Using this framework, the researcher could assess the actual level or degree of client experiencing with regard to each of these seven variables. Moreover, these ratings could be reliably based on specifiable client interview behaviors.

This idea of measuring tape-recorded interviews with a classification system of different types and qualities of in-therapy behavior was not entirely new. For instance, Zimring had developed an early classification system for client verbalizations, which included classes for direct reference to experiencing that lacked conceptualization (see Gendlin and Zimring, 1955; and Gendlin, 1961a).

In this instance, Rogers designated seven process variables. For each of these seven variables, there are seven distinct aspects or "stages" of interview behavior, which characterize differing levels of direct felt experiencing. Thus, for example, there are seven levels of experiencing with regards to the first variable listed above: feelings and personal meanings. At the lowest level (stage 1), "the individual is largely unaware of his feeling life." At the highest level (stage 7),

new feelings are experienced with richness and immediacy, and experiencing is used as a clear and definite referent from which further meanings may be drawn... The individual is able both to live in his own feelings and personal meanings and to express them as an owned and accepted part of himself" (Rogers and Rablen, 1958).

In general, the research method for the Process Scale involved first recording entire therapy sessions, and then randomly selecting 4-minute taped segments from early and late periods in therapy. These tape recordings would then be re-recorded onto small separate coded reels. In this

way, raters were blind to the identity of the counselor, ignorant of the therapeutic outcome of the subject, and did not know whether the interview segments were early or late in therapy. In the course of developing the Process Scale and this research approach, it was found that undergraduates who were untrained in psychotherapy or clinical theory could use these rating scales very reliably. In fact, the undergraduate raters showed more agreement than trained clinicians, who often tended to disregard the scales and use their own subjective impressions (Gendlin, 1966a, p. 7).

The first established version of "the Process Scale" was reported in Rogers and Rablen (1958). In the following years, the methodology of the Process Scale was continually modified, revised and improved as the scale was applied to therapy research (Rogers, 1959b). In particular, there were efforts to further define and differentiate the precise observations on which the Process Scale ratings were based [notably, Hart (1960); Gendlin, Hart and Tomlinson (1959); and Tomlinson and Hart, (later published in 1962), working at the University of Wisconsin; and Holloway (1960), and Zimring (1958-1959), at the University of Chicago]. An informal pilot study by Heisel sought to determine whether the scale had validity and could be used reliably. Heisel's study was significant because he extracted interview segments from different interviews rather than using entire interviews. This method represented a great economical savings in the scientific analysis of therapy

tape-recordings, and it was applied in all subsequent studies using the Process Scale.

Basically the client-centered researchers concentrated on two primary revisions of the Process Scale. First of all, they endeavored to ground each stage of the seven process scales in more precise specifiable descriptions of in-therapy client behavior. Secondly, they sought to measure the process variables of each of the seven strands independently of the other strands. For instance, van der Veen (1960) found that both reliability and validity improved when raters employed each strand separately.

Walker, Rablen, and Rogers (1960) put the improved Process Scale to its first rigorous test, and found that it had validity and the strands could be rated reliably. In the next study, Tomlinson (1959) noted the interesting fact that there were no clear differences between individual client process scores regardless of therapy outcome or whether they were taken from early or late interviews. Subsequently, Hart (1961) found that there was a great difference between the interrater reliability found in Tomlinson's (1959) study and other earlier studies. Hart sought to clarify those rating materials and conditions that made for optimally reliable ratings. Another validation study was undertaken by Tomlinson and Hart (1962), which was based on the findings of the above studies. By subtracting early process scale scores from late scores, Tomlinson and

Hart were able to compare cases according to actual process change regardless of case length. In another important validation study, Tomlinson (1962) found that four of the seven scales of the Process Scale were so highly inter-correlated that only a single scale was necessary. This new single scale became known as the Experiencing Scale (EXP Scale).

On the whole, the early studies using the Process Scale relied on ratings of the experiencing level of neurotic patients (Gendlin, Klein and Tomlinson, 1962; Tomlinson, 1959, 1962; Tomlinson and Hart, 1962; Walker, Rablen and Rogers, 1960; van der Veen and Stoler, 1965). These studies converged on the central discovery that clients who were rated high on the Process Scale tended to be more successful in therapy. Moreover, this was true whether process ratings were taken from early or late in therapy. Thus the process ratings overwhelmingly agreed that the more successful client began as well as finished therapy at a significantly higher level of process as compared to the less successful client. Success and failure in these studies was typically defined in terms of changes indicated by independent pre- and post-therapy psychometric measures, such as the MMPI and TAT. Actually these findings were foreseen by Kirtner and Cartwright (1958a, 1958b). They were able to make accurate predictions of length of therapy and of success and failure based on observations of the client's manner of relating to his problems in the first two interviews!

Also during this time period, Carl Rogers and his client-centered colleagues moved on to study the effects of individual psychotherapy with hospitalized schizophrenic patients. For this purpose, they organized a massive and elaborate five year research project called the Wisconsin Schizophrenia Study. During the years 1958-1963, Gendlin was research coordinator for the Psychotherapy Research Group of the Wisconsin Psychiatric Institute at the University of Wisconsin, and he had a leading role in the development and implementation of this project. In Rogers' own words,

Gendlin initiated the program, with all of the detailed arrangements which that implies, and has contributed a basic theoretical formulation upon which a number of our process measures have been built (Rogers, et al., 1967, p. xviii).

The "Schiz Study" had two primary goals. First of all, they wanted to convincingly demonstrate that client-centered therapy could be as effective with schizophrenics and normals as it had been with neurotics in out-patient settings. Thus they wanted to expand the clinical domain of client-centered therapy to new areas of practice (van der Veen, 1970). Secondly, they wanted to confirm the basic theoretical formulations of Carl Rogers, which are probably best summarized in his classic 1959 paper, "The Necessary and Sufficient Conditions of Therapeutic Personality Change" (see Section 11). The basic hypothesis of the Wisconsin

Schizophrenia Study predicted that positive client change would occur to the degree that congruence, unconditional positive regard, and empathic understanding were achieved in the relationship and perceived by the client. The crucial measure of process movement in therapy in this research was the newly revised and improved Process Scale (described below).

A few words can be said about the basic design of the Wisconsin Schizophrenia Study. There were three groups of 16 subjects: "chronic" schizophrenics, "acute" schizophrenics, and normals. The subjects were carefully matched to insure that they were equivalent in sex, age, and socio-educational level. Each of the 8 participating client-centered therapists (including Rogers and Gendlin) was randomly assigned triads from the three groups.

There were three major "clusters" of variables in the experiment. The first cluster of variables consisted of measurements of the degree to which the client-centered attitudinal conditions of congruence, empathic understanding, and unconditional positive regard were attained in the therapeutic relationship. These conditions were measured with rating scales, which objective judges applied to therapy interview segments. This cluster also included the Barrett-Lennard Relationship Inventory (given to both therapist and subject) to measure the degree to which the pair perceived the establishment of these

conditions. The second cluster consisted of the measures of therapeutic "effectiveness." These outcome measures included the MMPI, the Rorschach, abbreviated versions of the Thematic Apperception Test and the Wechsler Adult Intelligence Test, the Stroop Interference Test, the Truax Anxiety Scale, the Butler-Haigh Q-sort, the Wittenborn Psychiatric Rating Scale, and the Therapist Rating Scale. All of the measures in these two clusters were taken at specified intervals during the treatment period (i.e., 3 or 6 month intervals).

Finally, the third major cluster of variables consisted of the process measurements of the therapeutic experience. Basically, there were four process scales: a scale for the rating of (1) experiencing, (2) personal constructs, (3) manner of problem expression, and (4) manner of relating. I will describe each of these scales very briefly. The complete description of these measures is provided in the appendix of Rogers, et al (1967, pp. 589-611). It should be noted that Gendlin was involved in the construction of the first and last of these scales.

(1) The experiencing scale has seven stages. At the lowest stage, the client narrates events without any reference to how he is personally involved in the story. He reveals nothing about his feelings, attitudes, or reactions. At the middle stage 4, the client describes his feelings and self-concept by using his "story" to communicate his self. The client is aware of his feelings and able to express them, although he is not using them as a basis for understanding himself. At the highest stage 7, the client does not even need a narrative. He presents an immediate picture of what his attitudes and feelings mean to him, and "moves easily from one inward reference to another." His

feelings have primacy in determining verbalizations.

(2) The scale for rating of personal constructs measures the ways in which the person "construes" (i.e., perceives, evaluates, and interprets) varying situations and experiences. At the lowest stage 1, the client reveals nothing about his attitudes and beliefs about the world and himself. Everything he says is banal, trite, irrelevant, and void of personal meaning. At the next stage 2, personal constructs are extremely rigid and seen as facts by the client. The client shows no awareness that external situations are subject to varying interpretations. At the middle stage 4, personal constructs are still rigid, but there are occasions when the client recognizes that his perceptions of the situation may not be correct. However, he does not explore alternative ways of construing experience. At the highest stage 7, constructs are no longer seen as solid guides for behavior, and are instead used as flexible ways of construing any given moment of experiencing. All interpretations and perceptions are checked and rechecked against the ever-changing flow of experiencing, and are subject to constant modification in light of present events.

(3) The scale for rating the manner of expression is a bit different than the other scales because it utilizes a hierarchical format. Movement up this scale designates the deepening involvement of personal feelings in the client's expression of his problems. At stage 1, the client says nothing about his difficulties or problems. At stage 2, the client talks about his problem in a general, detached way. At stage 3, the person includes himself in a specific way when describing the problem situation. At stage 4, the client talks about his own feelings and reactions to the problem. At stage 5, the client acknowledges his own role in making the problem. At stage 6, the person describes how he comprehends the meaning of his feelings and reactions to the problem. At the highest stage 7, the client describes an actual resolution of the problem in terms of changes in his feelings and attitudes.

(4) Finally, the scale for rating the manner of relating deals specifically with how the client experiences the therapeutic relationship. At the lowest stage 1, the client flatly refuses any close personal relationship at all. At the middle stage 3, interchange in the relationship has an "intermittant" quality. At times, there is a clear indication of a valued personal relationship in which statements by the therapist are important to the client. At other moments, the client and therapist seem to seriously misunderstand each other and the client is hesitant about expressing deep feelings. At stage 4, "both individuals explicitly show that they assume the relationship to be one of sharing, intimacy, personal and self-focused or other's self-focused communication" (Rogers, et al., 1967, p. 609).

While at the highest stage 6, the person to person "togetherness" is a given natural state, in which nothing more about the relationship needs to be "worked through" (except maybe termination).

In conclusion, the Process Scale represented a highly economical measure of the on-going experiential process of therapy. It had the advantage of gathering information from a broad range of interrelated process events in therapy, and summarizing this data into a few quantitative values. The client-centered researchers endeavored to establish clear observational guidelines for making reliable Process Scale ratings. Certainly one of the tremendous advantages of the Process Scale was that it could give a reliable general measure of client experiencing, with the convenience of using only brief excerpts from tape-recorded interviews.

On the other hand, there are two problems with the Process Scale measure. The first problem is that it provides only a gross measure of the therapy process. The measures used in the Process Scale studies are so global that they "overlook" a lot of valuable information about specific in-therapy behavior. It is analogous to trying to evaluate the quality of a basketball team's entire winning season with a single global measure of "team spirit." Perhaps it was the way the team came from behind to win 45% of their games; or how they won every game in overtime; or how they consistently won the most important games in their own division; or a host of other factors and combinations of

factors. Conversely, there is only minimal indication of what actual process events constituted the raters' assessment of the level of client experiencing. Without precise guidelines for determining these ratings, there is no way to discern what sorts of therapy observations contributed to the judges' process ratings. However, for the most part, this disadvantage is outweighed by the greater advantage of research economy afforded by the Process Scale methodology.

The second, and more serious problem with the Process Scale methodology, is the way that high scores on the process scales were theoretically equated with successful outcome of therapy. This second disadvantage is the more fundamental problem of tautology. Gendlin (1962a, p. 267) unequivocally declares that "experiencing is a process that brings about therapeutic change." If experiencing is held to be the key process responsible for therapeutic change, then, by definition, experiencing level is a direct measure of the effectiveness of on-going therapy. In fact, the Wisconsin Schizophrenia Study and several later studies continued to uphold this same basic finding from the early Process Scale studies: clients who showed a certain manner of interview behavior (one characterized by high levels of felt experiencing) were those who showed successful therapy outcomes (Gendlin, 1966; Matarazzo, 1965; Truax, 1963; Rogers, et al., 1967).

However, this tautological problem with positing the "equivalence" of "experiencing level" and "effective psychotherapy" leads to a basic confusion. It is analogous to a hypothetical psychoanalytic researcher, who feels that "insight" is the key to effectiveness of therapy, and designs a quantitative measure of "amount of insight" gained in therapy. He then finds that patients who showed success, as measured by changes on personality test measures, also showed high scores on the "insight" measure. Since the psychoanalytic researcher assumes that "insight" defines effectiveness, he thereby concludes from these correlational results that insight was the "cause" of positive therapeutic outcome. Section 19 will critique this basic problem of interpretive ambiguity, which arises from the correlational paradigm that is typically used in Gendlin's experiencing research and the Process Scale research. In brief, the most serious error in using the correlational method "arises from investigators' tendencies to assign it powers of proof that it does not possess and thus to draw unwarranted conclusions or inferences from the data it provides" (Shontz, 1965, p. 158).

Finally, there was one other extremely important outcome of the Wisconsin Schizophrenia Study that was entirely unexpected. Rogers, Gendlin, and the other therapists found that working with recalcitrant schizophrenics (and normals) necessitated some drastic changes in client-centered practice, and these modifications

impacted on the therapy as a whole. Specifically, the client-centered therapists in the Schiz Study had to learn to handle such new obstacles as (1) extended periods of uncommunicative silence, (2) "total rejection of the whole prospect of a relationship," (3) failure to develop "a sense for the self-exploration process of therapy," (4) the lack of any self-motivated process, and (5) the extraordinary isolated or disconnected quality of schizophrenia (Gendlin, 1964b, 1972).

Working with schizophrenics taught us a much wider vocabulary of behavior, a much wider range of what one might do, what one might be pushed into doing by one's own feelings and own needs, in order to reach a person not being reached...

In order to make something happen, a therapist can use not only what the client is expressing and going through, but also what he himself, as a therapist, as a person in this moment, is going through. While the client may give me very little to go on, I have all the events going on in me to use in order to make something happen (Gendlin, 1964b, p. 172, first italics added).

In short, the client-centered therapists learned to rely much more heavily on their own feelings as a basis for treatment, often asking themselves, "what is my response as a person to this other person?" This technical development was also consistent with the general historical trend toward greater emphasis on therapist congruence. Another promising observation was that the minimal statements and nonverbal behavior of the schizophrenic frequently arose "from a very eventful, concretely felt process-- and that the interactions with the therapist are affecting or enabling

this process" (Gendlin, 1962c, p. 211; see also Gendlin, 1963a, 1972).

Above all, it became clear that the central experiencing process encompassed both continual focus on the client's felt experiencing as well as expression of the therapist's own experiencing in the relationship. Hart (1970) sees this new emphasis on the experiencing process as marking the opening of a new period in client-centered therapy, which he calls "experiential psychotherapy" and dates 1957-1970.

In closing, the completion of the Wisconsin Schizophrenia Study marked the end of an era in the client-centered movement. Following many active years of fruitful research and theoretical development, the Wisconsin Schizophrenia Study was in some ways a disappointment and a finale. Although the results enhanced knowledge about therapy with schizophrenics and suggested many new methods and areas of research, the results were generally inconsistent and undramatic. Furthermore, serious personal conflicts among the primary authors of the project caused lengthy publication delays that reduced its impact on the field (see Kirschenbaum, 1979, pp. 280-289).

In the wake of this mixed success, Carl Rogers moved into new areas, such as student-centered education (Rogers, 1969) and encounter groups (Rogers, 1970). At the same time, Gendlin's interests turned to pursuing the practical,

theoretical, and philosophical implications of his original experiencing conception. His years as a therapist and researcher in the client-centered orientation helped him to clarify his pre-theoretical descriptive notion of "experiencing" and distinguish it from Rogers' construct of "experience" (see Section 17). The publication of Gendlin's Experiencing and the Creation of Meaning in 1962 marked his philosophical break with the client-centered movement and divergence into the realm of experiential phenomenology and psychotherapy (see Sections 16 and 17).

15. Implications of the Process Scale Research.

The consistent results of the Process Scale research had tremendous implications for clinical practice. Above all, the Process Scale promised a reliable method of determining when therapy was being effectively conducted. Level of experiencing, as measured by the Process Scales, seemed to be an accurate index of the effectiveness of on-going therapy. However, the disturbing implication was that success was predictable right at the start of therapy! Stated simply, when experiencing level was low, therapy was not occurring.

The finding each time was that experiencing ratings of a few 4-minute segments predict success or failure with a high degree of statistical significance. We can now measure, while it is still going on, whether an effective mode of therapy behavior is occurring. [Namely that the client uses his immediate on-going experiential process as a basis for his thoughts and actions.] We need no longer wait some years for the outcome measures to tell us!

The implications for clinical practice and for future research strategy are quite momentous. Both practice and research procedures can now be instituted and tested by rating the subsequent interviews soon after whatever one does. In the past, each psychotherapy research study was condemned to require many years, until outcome measures were available, and each patient had to be left to continue whatever he was doing (often unproductive and ineffective), since there was no objective way to evaluate if his present therapy process was of an effective sort. [Gendlin, et al., 1968, p. 224, parentheses added].

These surprising results drew attention to two important distinguishable aspects of the experiencing variable: (1) degree of engagement in experiential focusing in therapy, and (2) increases in experiential focusing during the course of therapy. With regards to engagement, the studies consistently found that experiential level accurately predicted eventual success and failure of therapy for both neurotics and schizophrenics. The astounding implication of the Process Scale research was that success was predictable from the start of therapy: clients engaging in high levels of experiential focusing in therapy were those who showed successful outcome.

On the other hand, Gendlin and his client-centered colleagues were quite mistaken with regards to the second aspect of the experiencing variable: increases in focusing.

They had assumed that therapy naturally helped to teach a client to engage in experiential focusing. Therefore it was expected that effective therapy would be characterized by progressive increases in the client's level of experiencing across time. In terms of the Process Scale measure of experiencing, it had been predicted that successful clients would move up the scale over the course of therapy. In actuality, however, the client-centered researchers found that there was only a minimum of upward movement at best. Moreover, while the neurotic patients generally showed a fairly orderly linear change on the Process Scale over time, schizophrenics showed much more complex curves with both abrupt improvements and backsliding on the scale (Rogers, et al., 1967).

In light of the results of the many experimental studies using the Process Scale, Gendlin and his colleagues became convinced that level of experiencing was the crucial factor in psychotherapy. Therefore they set up an investigation to explore a series of five broad questions implied by these findings (Gendlin, et al., 1968):

1. Does experiential focusing define psychological adjustment?

At first sight, it appeared to Gendlin and his colleagues that focusing was necessary to move from maladjustment to adjustment, and so they wondered whether focusing by itself constituted psychological adjustment. However, based on clinical experience and the re-analysis of the Process Scale data, they concluded that many maladjusted clients do have this focusing ability, while many well-adjusted people are quite lacking in this ability. Therefore, in answer to this question, it was clear that focusing ability, by itself, did not define psychological well-being. In fact, Gendlin (1967a) related experiential focusing ability to a definition of the essential character of neurosis. The neurotic individual is (1) acutely sensitive to the way that his problems hinder his living, but (2) lacks the skill of experiential focusing to carry his feelings forward toward resolution.

2. Is focusing a skill or trait?

Secondly, Gendlin and his colleagues were curious whether focusing was a learned skill or a particular personality trait. To test this question, they administered two pages of instructions in how to focus (the Focusing Manual) to 47 high school students. Subjects' level of focusing ability was defined by scores based on judges' subsequent ratings of student answers to a short-answer Post-Focusing Questionnaire (PFQ). For a sequence of

open-ended questions, the judges used a 4-point rating scale ranging from certainty that the subject's response indicated experiential focusing to certainty that it did not. The Gendlin team then correlated the students' focusing ability scores with their individual scores on the fourteen factors of the Cattell High School Personality Questionnaire, a trait test. They found that focusing ability scores were significantly correlated with nine of the fourteen personality factors.

An inspection of the factors correlating with focusing (we had made no specific predictions) indicates that for the most part focusing ability is associated with just such traits as are akin to focusing thus giving a meaningful picture (Gendlin, et al., 1967, p. 233).

On the contrary, a closer examination of this research study suggests that there is no consistent "meaningful picture" here. The authors provided no rationale to explain why certain personality factors should be associated with focusing ability and why other factors should not, and they made no predictions about which personality traits would correlate with focusing ability. Without including an appropriate comparison group or manipulation, one might find that focusing ability correlates with any number of personality factors, or that some irrelevant variable like bowling ability is similarly "correlated with 9 of the 14 factors." In this case, Gendlin and his colleagues simply listed characteristics --such as "intelligence,

self-discipline, perseverance, staidness, and effective leadership"-- which had been found (post hoc) to be correlated with focusing scores. For instance, the authors are obligated to explain why "effective leadership" should "clearly" be more associated with experiential focusing than "poor leadership." The fact that the authors "made no specific predictions" in this study suggests that they had no such guiding rationale, and that this is little more than exploratory "grab-bag" research. Moreover, the most perplexing feature of this study is the authors' conclusion that they prefer to think of focusing as an ability rather than a personality trait. If this is so, one wonders what purpose this research has served.

In summary, this research study has a number of problems. First of all, there is a question whether the instructions actually induced experiential focusing and whether the judges' ratings provided a reliable measure of focusing. The inter-judge correlations were generally low, ranging from .108 to .482, and only one third of the Post-Focusing Questionnaire questions were "reliable and discriminated." Thus there is some doubt about the external validity of this focusing variable. Secondly, there is no clear cut rationale for what personality traits should be strongly associated with focusing ability. Thirdly, if focusing is an ability that can be taught rather than a personality trait, there is confusion about how these trait-test results are to be interpreted. Do certain types

of people learn to focus more easily, or do these types of people already have the ability? In short, the research never clarified the original guiding question of whether focusing is a trait.

3. What is the relationship between focusing and creativity?

In the next phase of this research, Gendlin and his colleagues turned to a third broad research question about experiential focusing (Gendlin, et al., 1968): the relationship between focusing ability and creativity. In contrast to the explanatory quality of the above study (which relied upon post hoc interpretation of results), this study had a clear theoretical rationale:

The ability to focus on concretely felt, but preconceptual aspects of the situation or problem one is presently experiencing is obviously necessary if one wishes to move beyond the definitions, constructs, and interpretations one already has... Creativity involves turning one's attention from the well-articulated explicit form in which one interprets something, to one's as yet unformulated felt sense of the whole situation-- exactly what effective psychotherapy involves. The creative individual is the one who doesn't scorn his vague impressions, who can stand a few moments of attention to his --conceptually vague-- but concretely felt impression, and who formulates these (Gendlin, et al., 1968, p. 233).

To test this hypothesis, the Gendlin research team administered a sequence of three tests to 22 college sophomores. First they completed a version of the

Gottschaldt Hidden Figures test (HFT), which involved finding simple geometrical figures embedded in more complex designs. The subjects then listened to tape-recorded instructions from the Focusing Manual, and completed the Post-Focusing Questionnaire (PFQ). Finally the students viewed a series of TAT pictures and wrote "as many stories as possible" about each picture in the allotted time. Using the median scores on the PFQ, TAT, and HFT, Gendlin and his colleagues separated the subjects into comparative groups of "focusers" and "nonfocusers," high and low scoring TAT groups, and high and low scoring HFT groups. A Spearman rank correlation of .44 was obtained between the TAT and HFT scores. No correlations between the two creativity tests and the PFQ were reported.

Using chi square analyses, Gendlin and his research team found that focusing ability was related to scores on the HFT, and unrelated to TAT Productivity scores. Since both tests were selected as measures of creativity, the authors had to explain why focusing ability was related only to hidden figures ability. The HFT test was considered to be related to focusing because it "measures the individual's ability to 'flexibly' adapt patterns, that is, to 'let go of' constructs or configurations when no longer appropriate to the situation" (Gendlin, et al., 1968, p. 235). [They note that Witkin refers to this embedded figures ability as "field independence" rather than "creativity" (Witkin, 1962)].

With regards to TAT productivity, the authors argue that in order to "let go" of a particular story theme to create a new story, the subjects also had to let go of their experiential sense of the stimulus picture. However, this argument assumes, first, that the focusing subjects were indeed in touch with their experiential felt sensing during the creation of the initial TAT story. Secondly, it assumes that an experiential sense is "singular" in the sense of yielding but a single story. This conflicts with Gendlin's own position that any given felt sense "contains" a wealth of implicit meaning that might be formulated in innumerable ways (i.e., multiple stories are therefore possible). It appears that the authors selected TAT Productivity as a creativity measure for a special reason, but then attempted to "explain away" the negative findings obtained. In the end, the authors conclude that focusing is related to a specific type of creativity, defined negatively as the capacity of letting go of given frameworks.

Based on the results of these two sub-studies on personality and creativity, Gendlin felt that they had succeeded in closely approximating the crucial therapeutic process of experiential focusing "in the laboratory." This raised the next major question of whether "experiential focusing" --as it was implemented by the Focusing Manual instructions, and measured by the PFQ-- was the same capacity that was responsible for high levels of experiencing in therapy as measured by the Process Scale.

As reported in the 1968 research article, Gendlin and his colleagues had initiated another new study to correlate focusing ability and experiencing level during therapy. This study was designed to "directly establish this presumed equation between focusing ability in the laboratory and experiencing level during therapy interviews" (Gendlin, et al., 1968, p. 235). Their plan was to use Process Scale measurements of in-therapy experiencing level as feedback on the effectiveness of various training procedures for focusing. Increases in experiencing level would indicate that the focusing training procedure was proving "effective." However, since this proposed study has never been published, it is possible that this research yielded disappointing results.

4. Can focusing be taught with procedural instructions?

The general line of research described above also emphasized what was probably the most important implication for psychotherapy: assuming that experiential focusing leads to positive outcome in therapy, can therapists learn ways to teach and directly facilitate this process? As we have seen, the client-centered researchers were surprised to find that experiencing level generally did not increase during the course of therapy. Therefore, assuming that high levels of experiencing characterize effective therapy, they were concerned with how to enhance the experiencing process in

therapy. Gendlin first pursued this issue by asking whether focusing was a trait or a trainable skill (Gendlin, et al., 1968). By 1969, he was convinced that focusing was a skill that could be learned (Gendlin, 1969a). In fact, it is fair to state that much of Gendlin's work following this period of experimental research in the late 1950's and early 1960's has been devoted to developing new and improved ways of teaching focusing (Gendlin, 1978, 1981).

5. What implications does focusing have for therapy effectiveness research?

Last of all, the consistent positive results from the Process Scale studies had major implications for future outcome research on psychotherapy. Basically, it questioned the established strategy of comparing a "treatment group" to a "no-treatment control group" as the way to determine whether a particular treatment was effective. In fact, according to Gendlin, the research suggested that often as much as one half of the presumed "treatment group" are not doing therapy (Gendlin, 1969a).

This assertion was entirely consistent with the contemporary experimental work of Truax and Carkhuff on psychotherapeutic outcome (Truax and Carkhuff, 1967). Based on their thorough review of the evidence for and against the effectiveness of psychotherapy, Truax and Carkhuff (1967, p.

18) argued that the extensive paradoxical evidence against psychotherapeutic effectiveness (Eysenck, 1971) "lies in the inappropriateness of comparisons between 'psychotherapy' and 'control' conditions of 'no psychotherapy.'" They argue that "psychotherapy" consists of a diverse collection of psychological conditions that produce varying degrees of positive and negative experiences for the client. Therefore it is inappropriate to compare a group of patients receiving "random unknown amounts of various psychological conditions collectively labeled psychotherapy" with another group supposedly receiving "no psychotherapy." For the same reason, Kiesler (1970, p. 251) has concluded that "outcome studies contrasting therapy patients as a group with control patients are doomed to failure."

Instead of this approach, Truax and Carkhuff (1967) advocated a drastic change in approach that focused on isolating and measuring the specific ingredients and conditions established in the therapeutic relationship. In short, psychotherapy research should concentrate on relating the effective antecedent elements and ingredients of the therapeutic relationship to constructive change in the client. This type of research approach would explain, for example, why Fiedler (1950, 1951) found that the quality and nature of the therapeutic relationship is independent of the individual therapist's actual training in the Adlerian, Freudian, or non-directive schools of therapy. The explanation is that any particular "school" actually

represents a heterogeneous collection of ingredients. Therefore research should focus on the specific effective conditions established by a therapist, regardless of his particular "school." In fact, Truax and Carkhuff (1967) dedicated their well-known book to identifying and measuring the specific conditions that contribute to positive and deteriorative client changes, and supporting these assertions with empirical evidence.

Based on his own extensive work in therapy research, Gendlin arrived at a very similar conclusion. Gendlin has advocated a new research strategy based on the fact that level of "experiencing" is an accurate indice of therapy effectiveness (Gendlin, 1969a; Gendlin, et al., 1968). Basically, the researcher institutes any experimental factor that is expected to influence therapy effectiveness, and then measures whether it raised or lowered the level of experiencing in subsequent interview sessions. For example, an experimental factor might be focusing instructions, imagery training, or some other "ingredient" of the relationship (to use the term of Truax and Carkhuff, 1967). In this way, the researcher can determine early in therapy whether the treatment is making a positive impact.

16. The Divergence of Experiential Psychotherapy from Client-Centered Therapy, Period V (1962-present).

At this point we have discussed four stages of evolution of client-centered therapy. In summary, the first period (roughly 1940-1948) was characterized by an emphasis on non-directive techniques. The second period (roughly 1948-1951) was characterized by a new emphasis on the vital therapeutic attitudes of the counselor. The third period (roughly 1951-1957) viewed the relationship as the key factor, focusing on the client's experience in interaction with the attitudes of the therapist. The fourth period (roughly 1957-1962) was distinguished by the emergence of the "new process conception" of human experiencing. During this fourth period, the focus was on the experiencing process of the client and they endeavored to clarify it theoretically, measure it scientifically, and facilitate it in clinical practice. Based largely on the research using the Process Scale, this "experiencing process" was identified as the index of positive therapeutic personality change. During this fourth period of evolution, client-centered research was clearly formulated in terms of Rogers' basic theory, and was aimed at relating this experiencing process to the techniques (from Period I), attitudes (from Period II), and interactive relationship (from Period III) established in client-centered therapy.

The fifth period of evolution arose from the vital discoveries that were made in clinical practice, theory and research during the fourth period. For organizational purposes, I have adopted the publication date of Gendlin's Experiencing and the Creation of Meaning (1962) as the transition to the new period. As we have seen, during the late 1950's and early 1960's, Gendlin contributed to the client-centered approach as a theorist, clinician, and experimental researcher. However, his role during this period was that of an important assistant seeking to advance the ideas and research of Carl Rogers and the client-centered program. Experiencing and the Creation of Meaning announced Gendlin's philosophical break with Carl Rogers and the client-centered orientation, and marked the independent pursuit of his own concerns. Also, at this time, the massive collaborative work on the Wisconsin Schizophrenia Project was being carried to a conclusion (although the publication of its results was delayed until 1967).

Undoubtedly, Gendlin's many fruitful years working with Rogers were extremely valuable because they helped him to clarify his basic ideas about experiencing. Clearly, Gendlin had always remained close to his original notion of "experiencing," which he had first described with Zimring in 1955. By the time of Experiencing and the Creation of Meaning, Gendlin had clarified the central distinction between his own pre-theoretical descriptive notion of

"experiencing" and Rogers' construct of "experience" (see Section 17). The clarification of this crucial distinction marked the central point of divergence between Gendlin and client-centered theory. This point was one of several general factors that contributed to Gendlin's departure from the client-centered orientation. For present purposes, it would be unnecessary to attempt to define the specific lineage of ideas, or critical historical events, or personal motives that created this divergence. Instead, in this section, I will suggest six basic points that conduced to this departure.

1. Philosophical interests.

Gendlin had been deeply involved in philosophy from the very beginning of his career. He had studied philosophy under Richard McKeon at the University of Chicago, and wrote his masters thesis in philosophy in 1950 on the topic of Wilhelm Dilthey. In fact, Gendlin has stated that he was "always the philosopher," even during his period of collaboration with Carl Rogers, and he planned to use what he was learning accordingly (Scharff, 1983). He had completed his doctoral dissertation on "The Function of Experiencing in Symbolization" in 1958, and this was later refined into his major philosophical treatise, Experiencing and the Creation of Meaning, published in 1962.

As Gendlin has explained in several of his writings, the basic ideas of his "experiential phenomenology" represent central philosophical issues in the existential and phenomenological traditions (see Gendlin, 1962a, 1965a, 1966b, 1973a, 1978-1979, 1979, 1982). In this regard, Gendlin notes the influence of such leading figures as Buber, Dilthey, and Kierkegaard, but most especially Heidegger (Gendlin, 1965a, 1965c, 1966b, 1967c, 1973a, 1978-1979, 1982, 1983), Merleau-Ponty (Gendlin 1964c, 1973a, 1973b), Husserl (Gendlin, 1965b, 1966b, 1973a), and Sartre (Gendlin, 1965a, 1965b).

Above all, Gendlin credits Heidegger as the most important philosophical "influence" on his thinking. In fact, he views his work as continuing from that of Heidegger. However, as Gendlin explains in the following passage, this influence was quite "indirect," and he did not realize it for many years.

My own work for many years preceded my reading Heidegger. I came to him quite late. Both the Personality Change theory (Gendlin 1964a), and the philosophical work (Gendlin, 1962a), were written before I read Heidegger. But I had read those philosophers that most influenced Heidegger, and so I emerged from the same sources, at least to some extent. I had also read Sartre, Buber, and Merleau-Ponty, who were greatly and crucially following Heidegger. Hence my own work continues from Heidegger, and stands under his influence, although I did not recognize that until later (Gendlin, 1978-1979, p. 70, reference dates added).

Since the client-centered approach has traditionally stressed scientific research and practical application, and has paid minimal attention to philosophical thinking, it was predictable that Gendlin would not find satisfaction for his philosophical interests here. In fact, his philosophical predilection flavored the way that Gendlin approached the ideas of Rogers at this time. As noted earlier (Section 12), Gendlin became intrigued by the theoretical problem that Rogers faced in the 1950's. Basically Rogers was trying to explain how personal meanings and feelings could emerge and even change during therapeutic interaction even though these experiences were supposedly not "in awareness." Gendlin recognized this as a philosophical problem, which was centered around the problematic ruling conceptions in psychology of "the unconscious mind" and "the contents of experience." He resolved the respective difficulties of the "repression paradigm" and "content paradigm" with the new process conception of experiencing (see Section 12) and the related notions of "implicit meaning" (see Section 3) and "felt sensing" (see Section 2).

2. Pursuing implications of the "experiencing" notion.

The second factor contributing to Gendlin's divergence was that the notion of experiencing was tremendously rich in its implications for psychology and psychotherapy. Indeed, the basic idea has been a wellspring for Gendlin for nearly three decades. This conception has required fundamental

re-thinking in many areas. In particular, it has necessitated modifications in the conduct and aims of therapy, the nature of personality theory, and the development and use of research variables to accurately capture the process of therapy. Furthermore, the idea of experiencing has required the development of methods to facilitate direct experiencing (focusing), and called for discussions to connect this thinking to contemporary phenomenology and existential philosophy. In fact, it would be accurate to describe Gendlin's career as a life's task of elaborating, clarifying, and unpacking the implications of this rich guiding conception called "experiencing."

In more recent years, Gendlin has been especially concerned with the philosophical implications of "experiencing." In particular, he has endeavored to blend this idea into mainstream philosophical thinking dealing with Heidegger (Gendlin, 1978-1979, 1982, 1983).

3. Achievement of the client-centered goals.

The third factor contributing to Gendlin's break was the successes of the Process Scale research. As we have seen, the extensive client-centered research being conducted during this time period was yielding consistent support for the essential role of "the experiencing process" in successful therapy. Gendlin was one of the leaders in this client-centered therapy research. The evidence from these

studies repeatedly found that the successful client was one who showed high levels of direct experiencing of feelings and felt meanings. In effect, this meant that Gendlin and his client-centered colleagues had accomplished two important initial goals. First of all, it had been successfully demonstrated that the new process conception could be scientifically studied with effective process variables. Secondly, the Process Scale research had demonstrated experimental support for the idea that level of experiencing was the crucial factor in psychotherapy. Therefore, having accomplished both of these client-centered goals, Gendlin was at liberty to address new problems he was interested in.

4. Development of focusing methods.

The fourth factor contributing to Gendlin's divergence from client-centered therapy was the fact that experiential focusing had now been "proven" to be the crucial factor in effective psychotherapy. Convinced that effective therapy is characterized by experiential focusing, Gendlin now became concerned with finding ways to improve therapy by facilitating this process. In fact, Gendlin had begun training graduate students in focusing techniques as early as 1963 (Scharff, 1983). As described in Section 15, Gendlin and his colleagues began with the question of whether focusing was a trait or a trainable skill (Gendlin, et al., 1968). In conducting this research, they found it

was possible to provide brief procedural instructions for teaching focusing "in the lab." They also developed a judge-rated questionnaire (the PFQ) to evaluate "focusing ability" following the instructions in focusing. In this study, they explored the relationship between focusing ability and personality traits and creativity, and concluded that focusing was not a trait, but a trainable skill (Gendlin, et al., 1968). This research study represented the beginning of Gendlin's efforts toward improving methods to teach and facilitate "focusing" (Gendlin, 1981; see also Section 7).

5. Modifications of client-centered therapy.

The fifth point of divergence centered around Gendlin's recognition of some distinct shortcomings of client-centered therapy. Based on his own clinical practice, and especially his experiences in therapy with schizophrenics, Gendlin perceived certain limitations of client-centered therapy. Stated in brief, Gendlin realized that the key to the effectiveness of client-centered therapy was the manner in which reflective responding was used. Specifically, the therapeutic effectiveness of client-centered responding was enhanced by (1) insisting on "exact specificity" in responding to the client's feelings, and by (2) making sure that the client "checks inside" to see if the response accurately captures the crux of the feeling (see Section 9).

Not only did Gendlin become clear about the crucial importance of continual direct reference to experiential felt sensing, but he recognized that therapy could also proceed effectively by focusing on the direct experiencing of the therapist as well. Thus, one of his primary innovations of client-centered therapy called for increased therapist self-expression. This was especially necessary when working with recalcitrant or non-verbal schizophrenic patients (see Section 14). In particular, Gendlin advocated changing many of the "don't" rules of client-centered therapy into "do" rules. In this way, it became acceptable practice to do things like offer a personal opinion or interrupt the client to ask for clarification. Above all, Gendlin was pressing for therapeutic "focusing" methods that could directly facilitate the use of the felt experiencing process (see Section 7). The implementation of these constructive modifications constituted yet another avenue of divergence from the client-centered orientation.

6. Interpersonal difficulties.

Finally, it is likely that the personal difficulties that occurred between Rogers, Gendlin, Kiesler, Truax, and the other major researchers of the Wisconsin Schizophrenia Study also contributed to Gendlin's separation from client-centered work. Stated in brief, there were several years of "agonizing dispute" over the editorship and authorship of the project, which caused great delays in the

eventual publication of the research results (nine years from 1958 to 1967). The nature of this dispute has been described at length by Kirschenbaum (1979, pp. 280-289).

In summary, I have argued that six related factors contributed to Gendlin's divergence from Carl Rogers and the client-centered orientation following a long period of fruitful collaboration. Rather than attempting to explain Gendlin's personal motives and the historical events in this matter, I have simply suggested some general factors that led to Gendlin's divergence from client-centered therapy.

CHAPTER IV -

THE RELATION BETWEEN EXPERIMENTAL RESEARCH

AND EXPERIENTIAL PSYCHOTHERAPY.

17. "Experiencing" Distinguished From Rogers' Construct of "Experience".

The consistent central theme of this dissertation has been that subjective experiencing plays a vital role in the process of psychotherapy. However, in order to clearly understand and discuss this vital function of experiencing in therapeutic change, there is a need for a systematic theory of psychotherapy. Such a theory would provide a working terminology and framework for making statements about observations and subjective events in therapy. Unfortunately, as Gendlin (1962a) points out, standard psychological theories consist of a mixture of (1) theoretical constructs that do not have immediately observable experiential referents, or (2) terms defined by external observations, or (3) imprecise common-sense

language that refers to experiencing in a vague manner. In short, terms that refer directly to experiencing are needed to clearly define the vital role of experiencing on a theoretical level. This does not, however, mean that therapists have generally been cut of touch with the central therapeutic role of experiencing. Rather, thus far it has been impossible to be theoretically clear about the experiencing process because psychologists use terms that refer only to conceptual contents or externally observed behaviors, or they rely upon common-sense descriptive language that provides only implicit, imprecise references to subjective experiencing.

The contrast between Gendlin's notion of "experiencing" and the construct "experience" in Rogerian theory centers upon this basic issue. Rogerian theory, like other psychological theories about psychotherapy, has no terms that refer directly to experiencing. Thus, although Rogers does implicitly refer to the experiencing process in his descriptions of therapy, he does not have terms that refer to experiencing in his explicit formal theory. As a result, Rogers is theoretically unclear about the distinction between direct experiencing and formulations of experiencing [see Section 4).

As noted previously in Section 6, it is possible to refer directly to subjective experiencing without conceptualization. "Direct reference" occurs in

psychotherapy when a client points to "this feeling I have" even though he or she is still unsure what "it" is. Later, the client might label this feeling as "anxiety about divorce." This thought is a conceptualization of felt experiencing, rather than direct experiencing itself, which had provided the ground for this particular conceptualization. Direct reference and conceptualization are two distinguishable types of symbolization. In direct reference, the client uses symbols to point to, or refer to experiencing, but there is no representation or picture of what the given experiencing "is" (e.g., "I feel it strongly"). Whereas conceptualization uses symbols to represent that which is symbolized (e.g., "I am feeling anxious about divorce").

In the same way, perceiving can be contrasted with "a perception." For example, at this moment, this page of writing is one aspect of the phenomenal field of your on-going process of perceiving. To understand that "this is English printing" formulates an aspect of this complex on-going process of perceiving into content, a perception. This object of perception, or content, is not the same as the process of perceiving, which may or may not be formulated into any particular perception(s).

Experiencing is not known, observed, or referred to, except as it is "symbolized" in some way. However, it need not be symbolized in the sense of conceptualization. It may be symbolized by being "directly referred" to (Gendlin, 1962a, p. 238).

Gendlin's notion of "experiencing" can be differentiated from Carl Rogers' notion of "experience" in two ways. First of all, the Rogerian term "experience" usually is a construct that identifies all possible organismic events occurring at any given moment in the person-- events that are both "in awareness" and "denied to awareness." Gendlin's "experiencing" is not a construct because it refers to the actual immediately given phenomena in awareness. "Experiencing" is always "in awareness" as felt meaning. Secondly, the Rogerian term "experience" refers to explicit conceptual content. Whereas "experiencing" refers to the bodily-felt, implicitly meaningful datum in the individual's phenomenal field, which can occur with and without conceptualization into content. In both respects then, Rogers' notion of "experience" is a theoretical term that does not directly refer to experiencing. These points can be elaborated by examining Rogers' term "experience" as it is used as a noun and a verb:

Experience (noun). This term is used to include all that is going on within the envelop of the organism at any given moment. It includes events of which the individual is unaware (such as physiological aspects of hunger, or the impact of sensory events), as well as the phenomena which are in consciousness...

Experience (verb). To experience means simply to receive in the organism the impact of the sensory or physiological events which at the moment are transpiring... "To experience in awareness" ...means to symbolize in some accurate form at the conscious level the above sensory or visceral events" (Gendlin, 1962a, p. 241, quoting Rogers, 1959a, statement in parentheses added).

This quote reveals the use of "experience" as both a "construct" and as "conceptual content." With regards to the former, "experience" is a construct that refers to all the organismic events that are happening at any given moment in the person. These organismic events can be in awareness, or may exist at an unconscious level from which they can potentially enter awareness. By definition then, organismic events that are "not in awareness" or "denied to awareness" cannot serve as an immediately present, directly observable referent for the individual. There is a distinction between phenomenal data that is "in awareness," and data that is "in" the organism. In contrast, "experiencing" refers to the immediate flow of directly felt, implicitly meaningful datum in the individual phenomenal field. Thus "experiencing" is always a directly observable referent for the individual.

Secondly, experience is used by Rogers as conceptual content. In the above quote, Rogers acknowledges that "to experience in awareness" means to symbolize organismic events in some accurate form at the conscious level. In other words, to "symbolize accurately" means to conceptualize organismic experience into an explicit content that is "known." In this fashion, "experience" which was once on an "unconscious" organismic level is now directly equated with the explicit conceptual content into which it has been conceptualized. For Rogers then, "experience" consists of the contents in the person at any given moment,

and these contents are essentially the same whether they exist "in awareness" as explicit contents, or are "denied to awareness" because they lack conceptualization.

On the other hand, "experiencing"

is capable of many different conceptualizations, but is not itself explicit contents of such conceptualizations. To call it implicitly meaningful is to note that it can give rise to many conceptualizations, and conceptualizations can be checked against its implicit meaning (Gendlin, 1962a, p. 243).

In short, "experiencing" is immediately present and concretely felt, whether or not it has been conceptualized, and whether or not the conceptualization is "accurate" or "inaccurate." "Experiencing" is felt (as implicit meaning) rather than known (as explicit conceptual contents).

Having established the distinction between the terms "experience" and "experiencing," we can now return to the original issue in this discussion: in order to clarify and extend theoretical statement about psychotherapy and personality change, there is a need for theoretical terms that directly refer to experiencing. At this point, it is clear that Rogers' theory is inadequate in two basic ways: (1) direct experiencing is mistakenly equated with conceptualizations of experiencing that are "in awareness," and (2) it is not clearly recognized that conscious awareness contains implicit felt meaning.

This theoretical inadequacy is especially evident with regards to Rogers' idea of congruence. "Congruence" is defined as a state in which the individual's experience is in harmony with awareness and the explicit representation of the self-concept. Stated more exactly, congruence exists when there is agreement between the conceptual contents of awareness and the contents posited in the construct "experience." However, Rogers does not clearly recognize that "experience" and "congruence" are actually constructs that have no observable experiential referent (i.e., they are not the immediately observable events in the phenomenal field of the individual). The conceptual contents in awareness are congruent with a construct called "experience" rather than with actual direct experiencing. However, since "experience" includes events that are "in awareness" as well as events that are "denied to awareness," there is a serious problem with explaining how contents that are "unformed" or "unconscious" can be congruent with conceptualization and the self-concept:

Without a theoretical statement of implicitly meaningful experiencing..., the unanswerable question arises as to the meaning of "congruent with experience," since it is unclear just what in awareness is congruent! Not conceptualization, since no one could exhaustively conceptualize all possible meanings of even one experience. What then? The answer must be "feeling" ...There is no term for anything that in awareness implicitly contains meanings and values (Gendlin, 1962a, p. 255).

It will be recalled that this "unanswerable question" first attracted the attention of Gendlin in the mid-1950's (Gendlin and Zimring, 1955; see discussion Section 12). Gendlin recognized that theoretical unclarity underlay the absurd claim that a conceptualization can be "exactly congruent" with "yet unformed emotional experience." To make such a claim, Rogerian theory had to assume that all meanings already exist as "contents" in "experience" and need only be conceptualized. Since Rogers' theoretical terms dealt only with psychological events that are accurately conceptualized, or treated as if they were, he could not make a clear statement of his idea of congruence and adjustment. Therefore Rogers mistakenly asserted that therapeutic change was a process of accurately conceptualizing the already existing "contents" of "experience," and bringing them into congruent conscious awareness.

What Rogers meant to say is that there is a certain manner of having experience that can be congruent, even though it is not clearly conceptualized in awareness. Gendlin realized that these theoretical problems could be cleared away by restoring the intended reference to experiencing: specifically, by introducing terms that refer to experiencing as an aware feeling containing implicit meaning. This theoretical clarity could then enable therapists to describe and explain what they observed in therapy with much more precision. Moreover, as we will see

in the next section, theoretical clarity can advance experimental research on the psychotherapeutic process.

18. Experiencing and the Correlational Research Paradigm.

In the previous section, we noted the tremendous importance of theoretical clarity regarding the experiencing process. This enabled us to make a clear distinction between Carl Rogers' construct of "experience" and Gendlin's notion of "experiencing." This clarity helped us to understand some of the problematic inconsistencies in Rogers' theory. In addition, establishing theoretical clarity can serve to enhance experimental research on psychotherapy and personality change. At this point, we have established (1) the need for terms that refer to direct experiencing, and (2) the distinction between "experiencing" and constructs that imply experiencing.

The first task for research theory is to carefully distinguish terms that directly refer to experiencing from constructs that are defined operationally or by external observations. This does not mean that terms, which are defined by direct reference to experiencing, should replace or preclude these other terms. On the contrary, clearly

defining terms that refer directly to experiencing should further the formulation of better research hypotheses and operational procedures. Hypotheses can be "made better" in the sense that implicit references to experiencing can now be made clear, precise, and communicable. In this way, theoretical exactitude can advance the scientific study of the role of experiencing in the therapeutic process.

According to Gendlin, the key to achieving this improved research is "restoring the intended reference to experiencing" (Gendlin, 1962a). This can be done in two directions: (1) by translating terms that refer to experiencing into externally observable terms and operational language, and (2) by retranslating operational conclusions into terms referring to direct experiencing.

As we have seen, client-centered researchers were especially concerned with finding ways of objectively measuring the process variables of "the new process conception." In view of the present discussion, we can ask more specifically whether Gendlin and his colleagues were successful in translating terms directly referring to experiencing into objective measures. In other words, did Gendlin succeed in "restoring the intended reference to experiencing" with his research variables?

The first step in assessing this question is to lay out the basic ways that "experiencing" can, in principle, be "directly observed" in the process of psychotherapy. First,

and most importantly, "experiencing" is immediately and directly observable in the phenomenal field of the individual client. The essential nature of this felt experiencing has, of course, been described at length in the first chapter of this dissertation. Secondly, it is possible to identify physiological correlates of different modes of experiencing (e.g., Gendlin and Berlin, 1961; Don, 1978-1979). Finally, there are distinctive in-therapy behaviors that indicate the presence or absence of intense experiencing. For instance, level of experiencing is outwardly manifest in such cues as the client's manner of speech; facial and bodily gestures; explicit verbal reports; significant silences; atypical changes in posture and behavior; and quality of responding to the therapist. In this regard, the Process Scale methodology represents an elaborate and sophisticated system of defined observations, which external judges can reliably use to evaluate the level of client experiencing.

With this understanding of the basic ways that experiencing can be "objectively observed," it is possible to briefly review the Gendlin research to ascertain the ways in which "terms directly referring to experiencing" have been translated into quantitative measures: First of all, Gendlin, Jenney, and Shlien (1956, 1960) demonstrated that counselors could quantitatively measure the quality of experiencing occurring in therapy by using counselor-rating scales. In this study, they were able to measure the

counselors' observations of experiencing regardless of whether conceptualization into content was occurring.

Secondly, Gendlin (1961a) used a 32-item client Q-sort to demonstrate that it was possible to measure instances of direct reference to experiencing that involved little or no conceptualization into content. In this study, clients sorted self-descriptive statements that depicted instances of "direct reference" without regard to conceptual content. In contrast, the Q-sort method used in the Gendlin and Shlien (1961) study measured attitudes about immediacy of experiencing, but lacked statements that directly referred to experiencing itself.

Thirdly, Gendlin and Berlin (1961) showed that it may be possible to measure the physiological correlates of experiencing. In this study, a physiological GSR measure was considered to refer directly to level of experiencing.

Fourthly, Gendlin, et al. (1968) developed a Post-Focusing Questionnaire, in which subjects gave open-ended written responses to various questions about their experiences following brief training in experiential focusing. This study demonstrated that written self-reports of client experiences could be rated on quantifiable scales by outside observers. In addition, this research study showed that "experiential focusing" could be defined as an operational procedure-- specifically, a set of self-guided instructions in focusing.

Fifthly, the Process Scale research demonstrated that objective judges could quantitatively measure the level of client experiencing by "observing" and rating tape-recorded excerpts of therapy (Rogers, et al., 1967). Process Scale ratings were based on a system of specified behavioral observations of client verbal responding.

Lastly, it may also be possible to solicit direct client reports of experiencing, in which the client describes his experiencing as it is occurring. This potential measure has not been utilized in these studies, although it has provided a vital data base for non-experimental, clinical empirical studies.

From this review, we can conclude that there are a number of ways to translate terms that directly refer to experiencing into measureable variables. Thus, in summary, we have established that (1) there is great value in theoretical clarity about experiencing; (2) there is a need for theoretical terms that refer to experiencing; and (3) there are potentially reliable grounds for its observation and scientific measurement (i.e., the means listed above). However, it is still an open question whether these efforts have been incorporated into rigorous scientific research that yields persuasive experimental support for assertions about "the vital role of experiencing in the therapeutic process." To answer this question, we need to look more closely at Gendlin's basic "correlational" paradigm in these

studies on experiencing:

Experiencing (certain functions of it) is a process that brings about therapeutic change... Terms referring directly to experiencing... can ...be related to other kinds of observations so that operational research can test hypotheses thus formulated.

We shall then be able to test specific hypotheses of how experiencing brings about therapeutic change.

Of course, such hypotheses can then be reformulated as correlations between externally observable behaviors (related to experiencing) and psychologically defined observations. Theoretical terms referring to the process of experiencing can then be considered to refer merely to the behavioral observations. Now, however, to bring that stage of research about, we need terms that refer to, and can differentiate, experiencing itself, and can formulate hypotheses about the role of experiencing in therapeutic change (Gendlin, 1962a, pp. 267-268).

This statement reflects the basic "correlational" paradigm that Gendlin has used in his research on the role of experiencing in therapy. It essentially involves translating terms referring directly to experiencing into measureable observations, and then correlating them with empirical criteria of change. Thus, the basic paradigm relates one set of "experiencing" variables with another set of variables defining psychological change. In this way, Gendlin (1962a) holds that various research hypotheses can be stated in which particular changes in experiencing are predicted to bring about therapeutic change. This basic "correlational" paradigm is presented in Table A below:

TABLE A. Gendlin's Research Paradigm.

A PROCESS VARIABLES	B OUTCOME VARIABLES
<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">terms referring directly to "experiencing"</div> <div style="text-align: center;">↓</div> <div style="border: 1px solid black; padding: 2px;">external observations (related to experiencing)</div>	<div style="border: 1px solid black; padding: 2px; margin-bottom: 5px;">empirical criteria of "change"</div> <div style="text-align: center;">↓</div> <div style="border: 1px solid black; padding: 2px;">psychologically defined observations (i.e., measures of therapeutic effectiveness)</div>
1. Gendlin, Jenney & Shlien (1960): <u>counselor rating scales</u> (measuring "immediacy of experiencing")	<u>counselor rating of outcome--</u> (measure taken at 7th and final therapy session)
2. Gendlin (1961a): <u>client Q-sort</u> during and after therapy (measuring "direct reference" to experiencing)	<u>various measures--</u> counselor & client ratings of outcome & of change; TAT; Rorschach; Self-, Ideal-, Trait-Feeling Q-sorts (measure taken after therapy)
3. Gendlin & Berlin (1961): <u>instructions</u> in modes of "experiencing" (operationally defined procedure)	<u>GSR physiological measure--</u> (measure taken during procedure)
4. Gendlin & Shlien (1961): <u>client Q-sort</u> (measuring attitudes about immediacy, <u>not</u> directly measuring "experiencing")	<u>various measures--</u> counselor & client ratings of outcome & of change; TAT; Self-Ideal Q-sort (measures taken at 7th and final therapy session)
5. Gendlin, et al. (1968): <u>judges' ratings of focusing ability</u> based on <u>Questionnaire responses</u> (measuring "experiencing")	<u>Cattell Personality Test--</u> (measure taken before focusing procedure)
*6. Gendlin, et al. (1968): <u>judges' ratings of questionnaire responses</u> (measuring "experiencing") *chi square analysis	<u>Hidden Figures Test, TAT Productivity</u> (HFT, then focusing, then questionnaire, then TAT)
+7. Rogers, Gendlin, Kiesler & Truax (1967): <u>four Process Scales</u> : manner of expression; personal constructs; experiencing; manner of relating (measuring "experiencing") +experimental design	<u>therapy effectiveness measures--</u> MMPI; Rorschach; TAT; WAIS; Stroop Interference; Wittenborn psychiatric rating; Butler-Haigh Q-sort; Truax Anxiety (measures taken periodically) <u>attitudinal conditions measures--</u> rating scales of congruence, unconditional positive regard, empathy; Barrett-Lennard Relationship Inventory (measures taken periodically)

As we can see from this table, there are two general sets of variables used in Gendlin's experimental research. The first set of variables ("process variables," side A) represent the various ways that terms referring directly to experiencing have been translated into measureable observations-- such as counselor ratings of client experiencing level (Gendlin, Jenney and Shlien, 1960). The second general set of variables ("outcome variables," side B) consists of empirical criteria of "change" (in therapy). These "outcome variables" do not refer to immediate experiencing, but refer rather to theoretical constructs without immediate experiential referents, or refer to externally observable behavior. The research hypotheses in these studies are formulated as correlations between the externally observable behaviors (related to experiencing) and the psychologically defined observations of change.

The underlying assumption is that the empirical criteria of change --such as the MMPI, TAT, Forbach, counselor ratings of outcome-- are reliable objective measurements of therapeutic change, whose external and internal validity has already been established through the accrual of replicable and cumulative research. Assuming the "strength" of these established empirical criteria, the research aim for Gendlin was to show that high levels of client experiencing (as measured by the "process variables," such as Process Scale ratings) correspond with psychologically defined positive change (as measured by the

empirical criteria, such as personality tests). However, the paramount experimental problem is to demonstrate that the co-relations between the two represent a genuine causal relationship. In short, the experimental task is to show that changes in experiencing level led to, influenced, or caused important psychological change.

Based on my review of Gendlin's research, my conclusion is that Gendlin's experimental work does not accomplish this goal: there is little convincing experimental support for the hypothesis that "experiencing brings about therapeutic change." However, before explaining this conclusion, it is crucial to first acknowledge the issue of whether the role of experiencing in therapy "requires" experimental justification. Gendlin can argue that there is no need for experimental "confirmation" of an insight that has already been "confirmed" at the phenomenological level and grounded in a systematic philosophy (see Section 20). Moreover, experimental confirmation would not confirm anything to someone who is convinced that "X" is true based on personal experience. For example, psychoanalytically-oriented therapists have conducted their form of therapy for decades with little concern for experimental confirmation of its effectiveness and guiding ideas (Luborsky and Spence, 1971; Luborsky, 1984). For the present, I will lay aside the issue of the experimental justification of experiencing (see Section 20). The fact is that Gendlin has more or less conducted experimental research toward the aim of

demonstrating that "experiencing brings about therapeutic change." And therefore, this research can be evaluated on the basis of its methodological merits.

19. The Limits of the Experimental Research in Experiential Psychotherapy.

As stated above, my overall conclusion is that none of Gendlin's experimental research constitutes strong support for the role of experiencing in therapy. There are three bases for this conclusion. First of all, two of the seven studies used college students rather than individuals in actual psychotherapy (Gendlin and Berlin, 1961; Gendlin, et al., 1968).

Second, and more importantly, careful analyses of these research studies has revealed serious methodological problems in every case (with the possible exception of the Wisconsin Schizophrenia Study; Rogers, Gendlin, Kiesler, and Truax, 1967). Some of the most glaring methodological problems are briefly summarized below:

In the Gendlin, Jenney, and Shlien (1960) study, there is the possibility of experimenter bias because the same counselor who rated the experiencing level for each client

also rated outcome of therapy. In addition, the "other evaluative measures of outcome" were left unidentified and unreported.

A second piece of research is strictly a preliminary study that has never been published (Gendlin, 1961a). In this study, Gendlin found that counselor rating of outcome appeared to be significantly correlated with the client Q-sort measure of "direct reference." Yet this Q-sort measure of experiencing was not correlated with any of the other tests used in the large battery of therapy outcome measures.

The study conducted by Gendlin and Shlien (1961) used a client Q-sort to measure clients' attitudes toward immediacy of experiencing. It is significant to note that this Q-sort is a measure of attitudes (i.e., a construct!) rather than a measure of immediate experiencing (i.e., a term referring directly to experiencing). Moreover, the only measure of outcome that was independent of direct client and counselor judgments of outcome (TAT score) was not significantly correlated with the Q-sort measure.

The psychophysiological study conducted by Gendlin and Berlin (1961) is riddled with problems, such as predicting the null hypothesis. The generalizability of the results of this lab study with students to the therapy situation is profoundly limited by the artificiality of the experimental procedure. There is serious doubt about the validity of the

experimental procedural instructions deemed to engender differing "modes" of experiencing in this lab study.

Another Gendlin study appears guilty of a sort of "grab-bag" approach, in which the researchers provided no rationale or predictions about why certain personality traits would correlate with focusing ability (Gendlin, et al., 1968). The second half of this study is suspected of discounting one of the two measures of creativity when it failed to relate positively with focusing ability.

In addition to these serious methodological flaws, there is a third fundamental problem with all of these studies: correlational research can rarely isolate crucial variables in a precise manner and determine which factor is responsible for which effects. Correlational research of this kind has the major advantage of allowing many behavioral aspects to be studied simultaneously with a minimum of interference with natural processes. It can yield intriguing leads and allows certain limited predictions, but it cannot determine the causal relationship between variables.

In Mahoney's review of the "12 most common experimental designs in therapy outcome research," the two types of correlational design used in the Gendlin studies are ranked as "the very weakest" (Mahoney, 1978, p. 666). In the Posttest only design, the subject or treatment group experiences a manipulation, and the dependent variable is

then measured. This first type of research is described as an "extremely weak and uninformative design; no strong conclusions can be drawn." In the Pretest-Posttest design, the dependent variable is measured before and after the experimental manipulation or treatment. This second type is also a weak design: "it may be concluded that there was (or was not) a change in the dependent variable, but one cannot determine whether this change would have occurred anyway (without the experimental manipulation)" [Mahoney, 1978, p. 666].

In most studies employing the correlational method, independent and dependent variables are fully interchangeable (Kiesler, 1971). However, as outlined in Table A, the process variables (side A) are essentially treated as if they are independent variables, while the outcome variables (side B) are regarded as the dependent measures: changes in level of experiencing (as measured with a counselor rating scale, questionnaire, Q-sort, etc.) is assumed to effect "outcome" in some way (as measured with personality tests, ratings of outcome, GSR, etc.). But, in any research using correlational data, it is not possible to ascertain the directionality of causation. Moreover, one cannot rule out the possibility that some unknown "third" factor has affected both variables.

Obviously then, to answer the paramount question of what in-therapy experiential events produce what sorts of psychological change, we need a situation in which the researcher can experimentally vary experiencing level in some way and look at subsequent client changes. Despite its many shortcomings, Gendlin's experimental research provides a good starting point and groundwork for implementing a much more rigorous experimental investigation of the role of experiencing in therapy. Gendlin's theoretical clarity about "experiencing" has advanced the need for terms that refer directly to experiencing (see Section 17); while his research has suggested a variety of ways to translate these experiential terms into scientifically measureable observations (see Section 18).

Moreover, a future program of experimental research on experiencing in therapy can benefit from the gains that have been made in outcome-research methodology since Gendlin's studies were completed in the early 1960's. At the forefront of these advances, has been the clarification of a methodological approach that can more or less "overcome" the problematic issue of defining what constitutes effective psychotherapy. Obviously there would not be such a plethora of psychotherapeutic schools existing today if they agreed on what constitutes "effective" therapy and how it should be properly conducted. It is just as problematic to try to establish some particular measure of effectiveness that could be generally agreed upon. The goals of therapy differ

greatly from one person to the next, and from one therapy situation to the next. Some consider therapy effective if it brings about "lasting positive personality change." This, in turn, raises the problems of how to measure personality change adequately: "how much" defines success in therapy; and "who" is the best judge of this change. Others, particularly the behavioral therapists, alternatively define effectiveness in terms of achieving pre-established goals, that have been stated as specific measurable changes in behavior.

Finally, there is another major problem with making claims about what is effective therapy. If one decides what constitutes "effective psychotherapy," then it tends to create a "self-fulfilling prophecy" of setting up and then finding these predetermined qualities or events. For example, Gendlin asserts that the central process of positive therapeutic change is "experiencing." Thus, if effectiveness of therapy is defined as a high score on the Process Scale, and a client subsequently scores high on this scale, then this is considered a "successful case." In other words, if therapeutic efforts are aimed at enhancing experiential focusing because this is deemed effective therapy, then it is a self-fulfilling prophecy to find that a focusing score has increased as a result of treatment.

To a large extent, many of these traditional issues have been circumvented by the new emphasis on the need for specificity in therapeutic outcome research (Berqin, 1971). Thus, probably the single greatest advance in outcome research has been the renunciation of the use of the classical experimental design: this traditional approach would compare a given treatment group(s) with a control group that was believed to be equivalent in every way except for not receiving the particular psychotherapeutic treatment. Gradually outcome researchers have come to the realization that

psychotherapy is such a heterogeneous collection of diverse and conflicting events that any attempt to definitively test its effect by virtue of classical pre-post-control group designs is doomed to failure...

This approach is about like asking "What are the effects of storms?" Which storms? Where? What kind of effects? What is a storm? Or it is like asking "What are the effects of medicine?" and then proceeding to collect a group of doctors practicing on patients to test for changes in "health," whatever that is (Berqin, 1971, p. 253, *italics added*).

Armed with this insight, the use of such gross tests of the effects of therapy have become "obsolete." A number of researchers have come to this conclusion, including Gendlin (1969a), Gendlin, et al. (1968), and Truax and Carkhuff (1967), [as discussed previously in Section 15]-- as well as Strupp and Berqin (1969), Kiesler (1970, 1971), Paul (1967), and Berqin (1971). It has been realized that it is essential to isolate specific variables and operations from the broad and complex enterprise that is psychotherapy.

Outcome research should be directed toward answering "what treatment, by whom, is most effective for this individual with that specific problem, and under which set of circumstances" (Paul, 1967, p. 111).

Based on this understanding of the need for specificity in outcome research, I can offer the following brief recommendations toward improving Gendlin's experimental research. At best, Gendlin's present research merely shows a certain degree of positive correlation between measures of experiencing and therapeutic outcome. However, the experimental goal is to demonstrate that changes in the empirical criteria of therapeutic outcome are due to changes in level of experiencing and not due to the effects of other factors. This goal might be accomplished by applying the principle of specificity to future outcome research on experiencing. Below are some general steps that could be taken toward this aim:

The first step is to define a target group of clients with a specific psychological problem. For example, the experiment could be limited to the treatment of college students suffering from depressive symptoms that meet the DSM III diagnostic criteria of Dysthymic Disorder. The criteria for subject selection could be further specified by establishing cut-off scores on certain appropriate objective measures like the Beck Depression Inventory. Thus subject selection could be restricted to those Dysthymic clients with scores ranging from 25-45 on the Beck Inventory. Subjects for the experiment could be recruited via the usual

intake procedures of a typical out-patient clinic setting, and randomly assigned to therapists by the social worker or other staff person at initial contact.

As a second step toward specificity, the therapists in the experiment could be carefully matched for such factors as age, sex, and years of experience. Moreover, the prospective therapists could be matched on attitudinal features such as warmth, empathy, and unconditional positive regard for the client. Reliable measures of these attitudinal or personality qualities have already been developed in outcome research in the client-centered tradition (Truax and Carkhuff, 1967). Using matched scores on these attitudinal measures, the study could claim equivalence of therapist's qualities previous to treatment as an additional aspect of experimental control.

The third step would be to precisely define what constitutes "positive outcome" in therapy. By restricting experimental participation to clients suffering from Dysthymic Disorder, for example, successful outcome could be appropriately defined as an alleviation of depressive symptoms. Thus one could use standard measures of depressive symptoms, such as the Beck Inventory. By administering the outcome measures at the beginning, middle, and completion of therapy, one has an objective empirical criteria of therapeutic change.

The fourth step might be to specify the circumstances under which therapy is occurring. For example, the selection and treatment of subjects could be defined as depressed (dysthymic) college students, who have been referred to a university out-patient clinic for time-limited treatment of 25 sessions once weekly.

The fifth and most important step is to define and specify what the "treatment" is. Luborsky (1984) has stressed the methodological necessity of insuring that the therapist is actually implementing the treatment which is hypothesized to cause positive outcome. As a psychoanalytically-oriented researcher, Luborsky has refined a "therapy manual" approach to therapy outcome research. In this methodological strategy, the therapists master an explicit guidebook, which emphasizes the practical in vivo application of concepts and techniques of the specified mode of therapy. In turn, there is an accompanying measure, which can quantitatively assess the degree to which the individual therapist has effectively applied the concepts and techniques from the manual. This measure provides a clear operational definition of the "purity" of treatment using the particular mode of therapy, and thereby constitutes a tighter experimental control over the treatment manipulation.

This "therapy manual" research strategy could be readily adapted to Gendlin's research. In fact, in the research study conducted by Gendlin, et al. (1968), Gendlin had already taken steps toward implementing this "manual" approach to therapy outcome research. Gendlin and his colleagues developed a Focusing Manual, which provided an operationally defined procedure for teaching experiential focusing. They also created a Post-Focusing Questionnaire (PFQ) as a measure of the degree to which the clients had learned to focus. In contrast to Luborsky's approach, which measures the degree to which the therapist is actually implementing the specified therapeutic treatment, Gendlin's research measures the degree to which the client has been effected by the "treatment" training procedure.

In fact, Gendlin reported a proposed experimental study that could have provided much stronger direct experimental support for the hypothesis that experiencing is crucial to effective therapy (Gendlin, et al., 1968, pp. 235-236). Apparently, the results were disappointing because this research has not been published or mentioned in any of Gendlin's subsequent writings. Nevertheless, this aborted experiment probably represents the most methodologically sound effort to directly test this hypothesis. In this proposed study, two therapy sessions were tape-recorded at the beginning of therapy for 10 clients. The clients then received instructions in focusing (the Focusing Manual) and responded to the Post-Focusing Questionnaire (PFQ) at the

end of the session. This was done twice in succession, and then two additional therapy sessions were tape-recorded following the focusing administration. Apparently, the sessions were tape-recorded in order to take advantage of the existing Rogerian Process Scale measures of experiencing level. As stated by Gendlin, this research design would allow them to experimentally test two hypotheses about experiencing in therapy: (1) whether focusing ability tends to enhance experiencing level in therapy, and (2) whether two administrations of the focusing instructions were sufficient to "teach" focusing. Ultimately, outcome measures could "confirm" whether the focusing procedure had raised experiencing level or not (assuming, of course, that experiencing is the basis for positive therapeutic change)..

In conclusion, Gendlin had the right idea in proposing this research, and future research can take advantage of the initial steps he had made in this direction. First of all, research can utilize the Process Scale methodology, which probably presents the most rigorous and reliable "direct" measure of immediate experiencing in therapy. Secondly, the "manual" approach seems very promising because it gives the researcher concrete evidence that the supposed mode of therapy is actually being conducted. In this regard, the Post-Focusing Questionnaire could be modified and refined to provide a direct measure of the degree to which the therapist is using discernible "techniques" to facilitate experiential focusing. Some of these experiential

techniques could include reflection of feelings; directing the client to "check inside"; asking the client to remain silent in order to let a felt sense form; following the experiential effects of a concept rather than its logical implications; and so on. In principle, there are many observable events that could be systematized into a measure of the degree to which the therapist is "treating" the client in ways that constitute "experiential psychotherapy."

Thus, in this way, one could have an experimentally controlled check of the "purity" of the experiential therapy treatment as implemented by the therapist. Moreover, this measure of the therapist's experiential treatment could be bolstered by a modified version of the already existing client Post-Focusing Questionnaire. This would enable the experimenter to assess the degree to which experiential therapy was being conducted by the therapist, and to what extent the client was being effected by this "treatment" in the enhancement of his or her focusing ability. Then the measures of focusing ability could be correlated with Process Scale measures of experiencing level. And, ultimately, if the Process Scale literature has been valid, one would expect a continued strong correlation between high levels of experiencing and positive outcome (as measured by such objective tests as the MMPI and Beck Depression Inventory).

The feature that has been missing from Gendlin's correlational research is an experimental control or comparison condition, which would allow causal inferences about experiencing and therapeutic outcome. We have already pointed out the problems with gross comparisons of "treatment" with "non-treatment" controls, and the need for specificity. In this instance, a more rigorous within-subject design is recommended, in which there are systematic internal experimental controls of when the defined therapy treatment is occurring and when it is not, and simultaneous measures of changes in experiencing level. Thus, in principle, it is possible to systematically measure the effects of "treatment" and "ineffectiveness of treatment." Finally, one could compare the efficacy of experiential treatment --for these clients with this specific disorder under these specified conditions by therapists with these measured personality characteristics-- with other treatment modes, such as cognitive therapy, or supportive-expressive therapy, which have already been systematized in the "manual" approach described by Luborsky (1984).

20. Is Experimental Justification "Necessary"?

In retrospect, we can see that Gendlin emerged from an exciting and crucial period in the client-centered movement, during which Carl Rogers and his colleagues were trying to experimentally test the effectiveness of this "new" type of therapy. Their intensive efforts to study therapy in a precise scientific manner raised the issue of what is really happening in therapy and how can one measure it? This vital concern with the adequate measurement of the authentic events in therapy gave birth to "the new process conception." Rogers and his client-centered colleagues wanted scientific methods that could study the essential fluid nature of the therapeutic process in all its richness. The crowning achievement of this research directive was the development and refinement of the Rogers' Process Scale (Walker, Rablen and Rogers, 1960).

Meanwhile, coming from a background in philosophy, and interested in learning about psychotherapy, Eugene Gendlin collaborated in this client-centered work by contributing the idea of "experiencing" to the new Rogerian concern with process. Within the broader context of the client-centered experimental program, Gendlin initiated some of his own experimental studies of the experiencing process in therapy. On the whole, Gendlin's research was methodologically flawed and inadequate, and it failed to produce any convincing experimental evidence of the presumed crucial role of "experiencing" in therapy. Yet, despite the shortcomings of his research, Gendlin was able to contribute theoretical

clarity to the process question, and also demonstrated several ways of translating terms that refer directly to experiencing into scientifically measureable observations.

Historically, it is evident that Gendlin ceased experimental research by the mid-1960's. In this final section, I would like to account for Gendlin's altered position regarding the role of experimentation in experiential psychotherapy. Stated in brief, it appears that Gendlin more or less realized the problems with trying to justify the importance of experiencing through experimentation. Hence, rather than try to criticize and improve the experimental research being done, or try to analyze the faulty philosophical basis for conducting more such experimentation, Gendlin felt that he could best justify his experiential method by doing it. In other words, he felt his energies were better spent developing improved ways of facilitating "experiential focusing." Gendlin recognized that experimentation is only one way of confirming the vital importance of experiencing in therapy. Thus, to some degree, it was irrelevant whether the supporting experimental research was strong or weak. For Gendlin, it was not important to gather experimental evidence for an insight that was already confirmed on other grounds.

While it is true that strong experimental evidence can function as a powerfully convincing argument, it is really only convincing to those who already believe in the confirmatory power of experimentation. Followers of the client-centered approach traditionally have received extensive training in experimental research method, and place great value on scientific evidence of this kind. In contrast, psychoanalytically-oriented therapists, for example, typically do not receive such scientific training, and are much less impressed by experimental confirmation (Luborsky and Spence, 1971; Luborsky, 1984). As a whole, psychoanalytically-oriented therapists have not sought experimental verification of their ideas, nor been swayed by experimental evidence regarding the effectiveness of varying types of therapy.

In short, client-centered therapy is founded on Rogers' firm commitment to the scientific study and validation of client-centered work. But Gendlin's experiential approach has a different foundation, and for this reason, he has not succumbed to an over-valued regard for the experimental justification of experiencing. Certainly he is not opposed to experimental research on experiential psychotherapy. For example, Gendlin presently makes use of his past experimental studies, but only as additional persuasion for those who already value such experimental evidence and are sympathetic to his experiential approach. Moreover, Gendlin would certainly agree that experiential events can be

scientifically studied. But Gendlin would vehemently oppose the claim that experimental confirmation of the importance of experiencing is necessary.

Instead, Gendlin has different grounds for the "justification" of the vital role of experiencing in therapy: what I have called (1) practical phenomenological grounds, (2) "case study" evidence, and (3) philosophical justification.

First of all, experiencing is justified by Gendlin's own personal clinical experiences in psychotherapy. This is what might be called the "practical phenomenological grounds" for experiencing-- meaning that it refers to Gendlin's own direct observations of what "really" happens in therapy. Drawing upon such confirming personal evidence is not unique to Gendlin. All of the great theorists of psychotherapy and personality invested years in studying clinical events, modifying their techniques, and experimenting with the effects of this or that approach. Freud is a prototypic example of someone who relied on personal experience and case study material to find his core factors of "effective therapy." Similarly, Gendlin spent many years practicing therapy in the client-centered orientation, where he observed the in vivo operation of "experiencing" as the fundamental process. He witnessed first-hand the phenomena he called "direct reference," "felt meaning," "experiential shift," etc. He learned how to use

conceptual knowledge "experientially," and he tested out various procedures of experiential focusing. Everyone knows how persuasive it is to experience something first-hand. Unfortunately, the drawback is that others are frequently skeptical or critical of the validity and reliability of personal clinical evidence. Hence, although evidence from clinical (phenomenological) experience is certainly empirical, and sometimes is very convincing, it tends to lack the "sales power" of experimental research in reaching the broader audience of experimentally-minded practitioners.

Gendlin's second ground for the confirmation of the vital role of experiencing is what might be called empirical "case study" data. As it is typically utilized, the case study method emphasizes the individual history and significant life events and relationships of the particular client. It explains how various experiences shaped the course of the individual patient's life and/or contributed to the development of his or her psychopathology. Gendlin uses the case study in an entirely different way. For example, in his book Focusing, he presents a series of clinical vignettes, such as "the man who felt inappropriate," and "the girl who was scared of college," and "the man who couldn't work," and so on. He describes nothing about the personal history of these individual clients. Instead he concentrates on describing the process of experiencing and its explication in each clinical case example. Thus he utilizes the common manner in which each

of these individuals engages in experiential focusing (each in his or her own unique style) to illustrate the crucial role of experiencing in therapeutic change.

Above all, Gendlin's main justification for "experiencing" is philosophical. Gendlin states that experiential focusing "is part of a wider philosophy" that "leads to a new method of human thinking" (Gendlin, 1981, pp. 165-166). Philosophical justification is probably the least convincing, and most difficult perspective to communicate to empirically-minded psychologists because they expect that any statement about a psychological phenomenon can be tested experimentally. They feel that claims about what constitutes effective therapy should be subjected to experimental verification.

As a philosopher, Gendlin's phenomenological approach is devoted to the clarification and affirmation of what human experience is essentially like. As we have seen, Gendlin has presented the notion of "felt meaning" or "felt-meaningfulness" to describe the fact that there is a concretely-sensed quality to any given moment of consciousness; and that this bodily-sensed quality implicitly "encompasses everything you feel and know about the given subject at a given time" all at once (Gendlin, 1981, p. 32). This is a Heideggerian notion of "being-in-the-world," which means that the experiencing of the individual never exists separate from the meaningfully

related world of events and people in which it occurs (i.e., "Befindlichkeit" --see Gendlin, 1978-1979). Heidegger clarified the basic relatedness between human existence and the world. Felt experiencing in any given moment implicitly contains the whole meaning of a given situation of living. Felt experiencing is a single bodily-felt beholding of the world by the individual, which encompasses present and past history, the environment, cultural significance, social relations, values, attitudes, perceptions, and so on.

Thus, for Gendlin, "experiencing" is not a mere "armchair theory" or conception about behavior in psychotherapy. For him, it is a description of the essential nature of human experience itself, which is consistent with a broader comprehensive philosophy of life. For Gendlin, to describe what it is like to directly experience life in the immediate moment does not require experimental justification. It is a given. The phenomenologist's aim is to present "what human experiencing is like" in a descriptive fashion that is affirmable by others. This means that others will agree with the phenomenological description not because of the precision of the argument, but because they find it accurately captures the essential quality of human living for them.

Hopefully, in presenting Gendlin's rich philosophy of experiencing, I have been able to use his descriptive approach to communicate what human awareness is like, both

in terms of everyday experiencing, and its role in the on-going process of psychotherapy.

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